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See page 111



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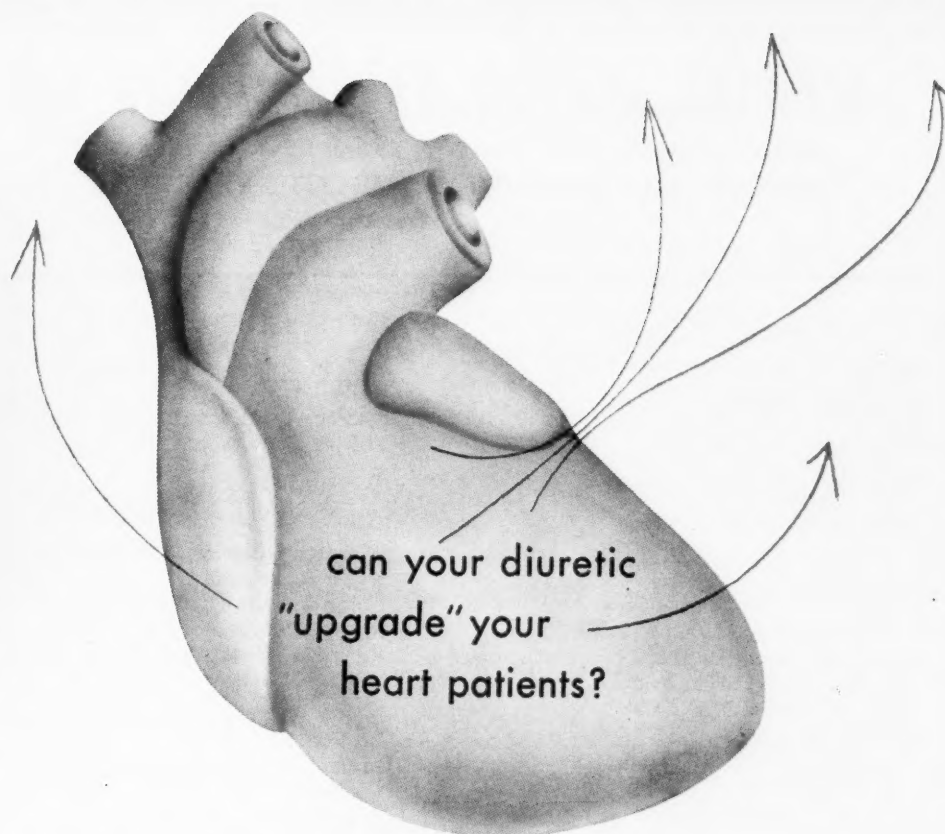
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Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: PETER PINEO CHASE, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Entered as second-class matter at the post office at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, \$2.00 per year.

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February, 1956

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PORK MAY be looked upon as an important factor in America's general health and well-being. The average intake of pork in America is about 46 pounds of lean pork and 20 pounds of bacon and salt pork per person each year.¹ But America's demand for pork goes further than taste appeal and deeper than mere statistics. Pork makes a valuable contribution to day-in-and-day-out nutrition.

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1. Consumption of Food in the United States, 1909-1952, Washington, D.C., United States Department of Agriculture, Bureau of Agricultural Economics, Agricultural Handbook No. 62, September, 1953.

2. Watt, B.K., and Merrill, A.L.: Composition of Foods—Raw, Processed, Prepared, Washington, D.C., United States Department of Agriculture, Agricultural Handbook No. 8, 1950.

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7. Estimated on basis of protein content of meats, Sherman H.C.: Food Products, ed. 4, New York, The Macmillan Company, 1948 p. 155.

8. Recommended Dietary Allowances, Washington, D.C., National Academy of Sciences—National Research Council, Publication 302, 1953.

Cooked Pork Chops, Ham, and Pork Sausage Nutrients and Calories Provided by 3-Ounce Portions							
TABLE I	Protein Gm.	Thiamine mg.	Niacin mg.	Riboflavin mg.	Iron mg.	Phosphorus mg.	Calories
Pork Chops, without bone, cooked, 3 oz. ²	20	0.71	4.3	0.20	2.6	200	284
Ham, without bone, cooked, 3 oz. ²	20	0.45	4.0	0.20	2.6	202	338
Pork Sausage, cooked, 3 oz. ³	14	0.42	2.8	0.20	2.1	139	396
3.5 ounces of fresh pork loin, equivalent to approximately 3 ounces of cooked loin, contains 0.47 mg. pantothenic acid; ⁴ 0.10 mg. pyridoxine; ⁴ 0.005 mg. biotin; ⁵ 36 mg. inositol; ⁴ 0.08 mg. folic acid; ⁴ 0.0027 mg. vitamin B ₁₂ ; ⁶ 63 mg. chlorine; ⁷ 0.1 mg. copper; ⁷ 20 mg. magnesium; ⁷ 280 mg. potassium; ⁷ 70 mg. sodium; ⁷ and 0.01 mg. manganese. ⁷							
Nutrients and Calories of Cooked Pork Chops (3 ounces) Expressed as Percentages of Recommended Daily Dietary Allowances ⁸							
Percentages of Allowances for:	Protein	Thiamine	Niacin	Riboflavin	Iron	Phosphorus	Calories
Girls, 13-15 years of age; weight, 108 lb.; height, 63 inches.	25%	55%	33%	10%	17%	15%	11%
Women, 25 years of age; weight, 121 lb.; height, 62 inches.	31%	59%	36%	14%	22%	17%	12%
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CONGENITAL HEMOLYTIC ANEMIA ASSOCIATED WITH SPHEROCYTOSIS*

Report of Four Cases

PHILLIP J. LAPPIN, M.D.

The Author. *Phillip J. Lappin, M.D., of Pawtucket, Rhode Island. Junior Assistant Physician, Department of Medicine, the Memorial Hospital, Pawtucket, Rhode Island.*

THE PURPOSE of this presentation is to summarize our present day knowledge of an hereditary type of blood dyscrasia and to report on four cases in the same family.

The disease in question is known by several names; familial hemolytic jaundice, congenital hemolytic jaundice, congenital hemolytic anemia. However, the term used by Dr. Dameshek,¹ "Hereditary Spherocytosis" seems to be a better choice in that it more accurately describes the fundamental disturbance. Hereditary spherocytosis is inherited as a Mendelian dominant and can be transmitted by either parent.² It is equally as common in males as in females, but is said to be extremely rare in negroes.³

Onset of the disease may occur at any time of life but it usually appears during childhood. In general, it can be said that the earlier the onset, the more severe the process is likely to be. I am unable to give the numerical incidence of this disease at this time, but in a series of 220 cases in which splenectomy was done for blood dyscrasia, over a ten-year period, 38 cases were of the spherocytic type.⁴

Of the three congenital hemolytic diseases — sickle cell anemia, Mediterranean (target cell) anemia and spherocytic anemia, it has been said that the spherocytic type is the most common.⁵ However, from the viewpoint of a general practitioner it would appear that hereditary spherocytosis is a relatively rare disease. This statement is borne out by the fact that a review of the records at the Pawtucket Memorial Hospital with reference to hemolytic anemias failed to disclose a single case so classified.

From the clinical point of view, hereditary spherocytosis is a chronic disease presenting an

*Presented at the John F. Kenney Clinic Day of the Memorial Hospital Interns' Alumni Association, at Pawtucket, R. I., November 9, 1955.

extremely variable picture. The symptoms may be so insignificant as to be overlooked. On the other hand, the chronic course might be interrupted by minor or major exacerbations which can be of sufficient severity as to result in shock or death.⁶ In minor episodes the symptoms are quite non-specific. In major episodes, or hemolytic crises, the symptoms are those of an acute illness and frequently suggest an abdominal emergency of a surgical nature. In some instances, a hemolytic crisis is the first manifestation of the disease.

In crisis, the symptoms are those common to all severe anemias, plus those due to the active process of blood destruction; these latter symptoms consist of malaise, nausea, vomiting, fever, chills and abdominal pain usually localized in one or both of the upper quadrants. During the crisis the red count might drop from 4 million to 1 million in 24 to 48 hours, and the blood picture is that of "pancytopenia, reticulocytopenia and extreme spherocytosis."⁷ Physical examination reveals unusual pallor and a varying degree of shock; splenomegaly is common; hepatomegaly is an occasional finding; upper abdominal tenderness is not unusual. Jaundice may or may not be present and if observed might not be marked. The upper abdominal pain is perhaps due either to enlargement of the liver and spleen and the stretching of their capsules or infarction in these organs. Hepatitis, cholecystitis and cholelithiasis are commonly associated and symptoms secondary to these complications must be differentiated.⁸

The average life span of a normal red cell has been shown to be about 120 days.⁹ During its life span the erythrocyte, which begins as a biconcave disk, becomes more nearly spherical as it nears the end of its existence. These spherocytes are apparently trapped in the spleen where they are broken down and their components, globin, bilirubin and iron are in large part returned to the circulation for redistribution into new red cells.

In hereditary spherocytosis, it has been postulated by some hematologists that there appears to be an intrinsic defect of red cell formation¹⁰ so that at birth the cells are spherical and therefore already

continued on next page

old. The usual life span of a red cell in Hereditary Spherocytosis is from 10 to 20 days.¹¹ The reason for this is that these abnormally thick cells are selectively trapped in the splenic pulp where they undergo a process of disintegration.¹² Cross transfusion experiments have demonstrated, to the best of present day knowledge, that the process is a result of red cell abnormality and not due to a disturbance of splenic function. Normal red cells transfused into patients with hereditary spherocytosis do not undergo spherizing, increase in fragility or abnormally rapid destruction.¹³ If spherocytic cells are transfused into normal individuals, they continue to live only 10 to 20 days. If the spherocytic cells are transfused into an individual who has had his spleen removed for a reason not related to spherocytosis, the cells live almost the usual 120 days.¹⁴ From these experiments it would therefore appear that the clinical syndrome in congenital hemolytic anemia will not appear if the spleen is absent. However, the explanation is not so simple. Granting the existence of a constantly defective red cell and the presence of a spleen, how are we to explain the exacerbations and remissions of this disease? How are we to explain the serial onset of acute hemolytic crisis in members of the same family?

That hemolytic crisis can occur in rapid succession in several members of the same family is beyond dispute. Evidently, then, it should be suspected that there is an extrinsic cause for the crisis. Dedechon,¹⁵ who had a relatively large series, felt that a contagious respiratory infection was responsible.

It has generally been considered that the Coombs Test would rather accurately differentiate the acquired from the congenital type of hemolytic anemia. The Coombs Test is a sensitive but non-specific method for the detection of antibodies which are adsorbed on the surface of the red cell. These antibodies, composed of globulin, form a coating on the red cell subsequent to exposure to a sensitizing substance described as an antigen, (penicillin, aspirin, incompatible blood type, RH factor, or any other material which can result in the production of these immune globulins). If human serum or globulin is injected repeatedly into an animal, usually a rabbit, an anti-human globulin is produced. If this animal (Coombs) serum is then mixed with human red cells, agglutination of the red cells will result only if the red cells are coated with antibody. This causes hemolysis of the red cells and is then reported as a positive direct Coombs Test. This is seen presumably only in the acquired hemolytic anemias. That this is not beyond question has been shown by one study in which four out of twenty-five cases of proved spherocytosis were shown to have positive Coombs Tests.¹⁶

Dameshek has demonstrated the presence of antibodies in three cases of hereditary spherocytosis during crisis.¹⁷ He has also observed the sudden and marked increase in the number of spherocytes during crisis. If one accepts as a fact that the cause of this disease is a defective red cell, then during crisis one would expect to find spherocytes in the bone marrow, but this is not the case; on the contrary, the marrow shows an almost complete maturation arrest.¹⁸ Coupling these studies with the facts that spherocytosis is also seen in the acquired hemolytic anemias in the active phase, and that spherocytosis can be produced experimentally in animals by sensitization, Dameshek concludes that the red cells are normal when produced, but become spherocytes because of the activity of an abnormal intra-vascular hemolytic mechanism—an auto-hemolysin (only active against the patient's own red cells).

If the causative agent is a pure auto-hemolysin we then can explain why transfused normal cells do not become spherocytes. We can also explain the serial crises within a family on the basis of release or activation of the hemolysin by an acute infection—a sort of trigger mechanism.

That normal cells transfused into a patient during crisis occasionally become spherocytic and therefore accelerate the hemolytic process (transfusion reaction?) could not be explained by this concept of etiology, unless one accepts the possibility that the causative agent might be an isohemolysin and not an auto-hemolysin. One then accepts the newer theory that the red cells are acted upon by an agent, an auto- or iso-hemolysin which converts them into spherocytes; the spherocytes are then destroyed by the spleen simply by an exaggeration of the normal hemolytic mechanism. The rapidly developing anemia in crisis results from the increased production of spherocytes and their subsequent disintegration in the spleen plus the maturation arrest in the bone marrow probably due to the increase in splenic activity.

The diagnosis of this disease depends on the usual criteria for any disease. The physical findings have already been discussed. The important relative items in the history are those of anemia with or without splenomegaly and/or jaundice in other members of the family. The laboratory tests will contribute a great deal. The red count and hemoglobin will reveal an anemia proportionate to the activity of the illness. The Coombs Test is usually negative. The stained smear shows many spherocytes. An important test is the demonstration of an increase in the mechanical and osmotic fragility of the red cells. A positive osmotic fragility test is quite reliable if the cells are first incubated for 24 hours at 37° C. Reticulocytosis is marked except in crisis.

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THE CROSSROADS OF ADOLESCENCE*

STANLEY H. CATH, M.D.

The Author. Stanley H. Cath, M.D., of Arlington, Massachusetts. Research Associate in Mental Health, Department of Public Health Practice, Harvard University School of Public Health; Clinical Instructor in Psychiatry, Tufts Medical School; former Intern, the Pawtucket (R.I.) Memorial Hospital.

THE ADOLESCENT has difficulty in coping with the world because on one day he clearly perceives all his inadequacies and is like a child; whereas, on the next he feels tremendously important and competent and will take advice from no one. Standing at this crossroad between childhood and maturity, he fluctuates with amazing rapidity between the poles of wavering uncertainty and extreme rigidity.

To understand the teenager, it is necessary to review the psychology of the family and the development of the child.

Every person has a mental picture of the family from which he came as a group and as individuals. We call this the family image. Research has recently indicated how important a part such an image plays in human behavior and motivation.¹ For example, one can easily conceive of the feelings of the person whose family background is characterized by hereditary diseases such as congenital hemolytic anemia or Huntington's Chorea.

To move into the psychological realm, we have heard families described as low class, blue blood, alcoholic, self made, no good, etc. Thus, each individual, as he becomes a parent, has already existing ideas and expectations associated with his past as well as his newly-formed family. The new child is frequently endowed with certain expectations derived from images and concepts held by the parent and based upon their conflicts in the past. For example, many children are expected to make up for the failures of their fathers. At the same time, ambition in the mother may seek fulfillment through the utilization of the child in achieving her goal. While the infant may cement a marital bond with an increase in mutual responsibility, it may also loosen it, because the new arrival calls for a shift in the arrangement and distribution of time and affection,

*Presented at the John F. Kenney Clinic Day of the Memorial Hospital Interns' Alumni Association, at Pawtucket, Rhode Island, November 9, 1955.

so that each member is necessarily divested of a certain amount of these commodities. The success of the family as a whole will then depend upon the preparedness of each member to relinquish a generous portion of affection, make many real sacrifices, and reduce to a minimum his own need to be the "only child."

Out of old, unsolved frustrations, the father may, without knowing, relate to his wife as he did to his mother, and the child may then become an undesirable rival or sibling to be stifled, ignored, and unconsciously wished away. This unconscious fear of rivalry may even result in the postponement of parenthood for years and, in particular cases, permanently. Psychiatry has only recently begun to investigate the relationship of such unconscious conflicts in both the male and female to infertility, premature births, and repeated abortions.

The sex of the child may or may not be a source of satisfaction—again, according to previous expectations and concepts of desirability of a boy versus a girl.

In the last fifty years we have become acutely aware of the fact that a child is not completely oblivious to the problems of rivalry, love, parental affection, etc. From a very early age he begins to ponder, both consciously and unconsciously, over the fact that there are two kinds of people, men and women, and that he is or is not physically and anatomically similar to one of these kinds. He must learn how to get along with both sexes and pattern himself after his father or father substitute in order to become a man. If his relationship with his mother is good, he learns to take a woman as a loved one and to associate a great deal of satisfaction and pleasure in his relationship with her. He deliberates upon his origin, purpose, and destiny and tries to answer perplexing questions, the same questions involved in the riddle of the Sphinx. He knows he has a place, but he does not know where it is, whether he can assert himself and still be a lovable person, and whether he can give love to others.

Certain areas of the body gradually come into focus. He soon learns of the exquisitely sensitive nerve endings that are so well distributed in particular areas of the body and that stimulating and exploring these parts is extremely pleasant.

continued on next page

To return to the infant for a moment, stimulation, exploration and gratification are, for the first year of life, primarily concerned with the mouth or oral apparatus. The child enjoys his food, sucking the breast or bottle, and using his fingers or thumb long after his basic food needs are satisfied. In this stage everything he finds goes into the mouth for exploration as he tries to test its size, shape, edibility, etc.

Very much aware of his own helplessness, he is only able to signal for help by crying, and his greatest fear is that of desertion. Assuming his chief distress of hunger is relieved again and again, he learns a sense of basic trust and continuity which serves him in great stead in later years.² If there are repeated frustrations and discontinuity in feeding, he may always be unable to tolerate waiting and frustration, handicapped by a sense of impending disaster and desertion. In the face of his helplessness and physiological limitations, the small infant, unable to clearly see his mother until after three months, sees the world only as an extension of himself to be summoned by his somewhat magical cry, and views the world as an annexational part of the self with no clear-cut distinctions between self and non self. If we were to devise a formula for this period of life, it could be simply stated as a great big *I* and an insignificantly small *you*.³ The child in effect says, "you are there to serve my needs (as in truth we are), and my very cry magically brings relief." Weaning can be said to be the first crisis in the child's psychic life.

In the second year of life another problem, and another part of the anatomy, the voluntary musculature in general, the anal sphincter more specifically, becomes the chief preoccupation. The problem is one of autonomy and a delineation of the areas over which the child has willful self control. He soon learns that he must express himself as an autonomistic person, separate from his parents, and that he must recognize what is his property, as defined by his environment, and what matters he must control. He must determine when dependency is acceptable and when it is not. For example, he must learn to stand on his own feet, control his bowel movements, and comply to the demands of his family for cleanliness, regularity, obedience, etc. Toilet training becomes a chief preoccupation of both parents and child, and society indicates that he must conform in order to be loved and retain the approval of his parents. Normally, the child has experienced only pleasure in his bodily excretions produced at will, but in face of social demands, he feels himself quite impotent and protests in outbursts of rage and rebellion at this need for conformity and at his elders' evaluation of his efforts. Fecal smearing is not uncommon. Thus, basic feelings of shame and doubt arise in this

period, particularly because shaming plays such an important part in attempting to acculturate the child. To test the limits of autonomy, every child risks being ridiculed and shamed repeatedly. From this period, which can best be formulated as the small *i* and the large *YOU*—because of the child's increasing awareness of his own size, authority, and limitations, there should arise a sense of autonomy and self control, encompassing the culturally evaluated concepts of property and propriety, but colored to various degrees by a sense of shame, impotence and exploitation. We know that the disturbed child may emerge at a later age as a bed wetter or as a person preoccupied with obsessive acts that are supposed to magically untie the roots of his uncontrolled hostility and rebellion. The greatest fear of this period is the loss of self control and the inability to gain approval. A balance between the need to exploit and permitting oneself to be exploited is needed.

We now come to the period of "childish romance," the ages approximately four to seven. Through the years the child has received considerable pleasure in the handling of his body by his mother. In daily bathing and in the increased awareness of his own body, he has learned that it is pleasant to be cared for, washed and handled, and even to stimulate his own genitals (the anatomical area of most urgent concern at this time). The child desires to repeat these experiences, and masturbation at around two to seven is a phase of growth rather than a moral inadequacy. Associating his bodily pleasure with people, especially his mother, he finds there are frequently other rivals for her affection who, indeed, may frown upon such actions: for example, his father. Not only are there siblings with whom he must share time, love and toys, but there is the father who looms more and more significantly on the child's horizon. He finally is likely to conclude that father is the most important person in his mother's life, the one on whom decisions wait, the source of power and authority, the sharer of mother's bed, and altogether a very powerful and frightening figure. In his fantasy he cannot help but wonder how nice it would be either to remove the father or take his place. Then he would be the one to run the house, distribute the money and candy, and have the power to command and refuse. In play and art (draw a picture test) almost every child reveals this fantasy. The magical resolution of the conflict has been immortalized by fairy stories in which the boy goes out to seek his fortune, slays an evil dragon or a cruel king, marries the princess or the queen and comes into his own; and, more classically, by the tales of Oedipus Rex. The formula here can be expressed as *I* replace *YOU*, and it has concealed in it the desire to annihilate all competitors. The

end result would be the much desired state, an only child with exclusive possession of the parent.

The result of this period of romance, if the child is fortunate, is a sense of initiative, colored, however, by great competitive destructiveness which results in daring play and forceful behavior. At the same time, the five-year-old begins to wonder if his father might not be aware of these aggressive feelings and his yearning to possess his mother exclusively. Because of this fear, he frequently develops what can be called "a normal neurosis" of childhood. Here he fantasies his father will retaliate for such envious thoughts. Fears and nightmares may develop in which he is being chased and pursued by horrible monsters from which he cannot escape. By the law of Talion, he expects to be annihilated. In order to preserve his closeness with his father, he unconsciously displaces his fears to innocuous objects such as horses, dogs, darkness and the like, but in so doing he develops his third great fear, a fear of mutilation and injury (of harm coming from an unknown, unkind source in the indefinite future).

If we apply what we have said, we would think of the world of the child as a place where he experiences the following conflicts which seek solution consecutively, and later even simultaneously:

1. The fear of desertion *versus* the secure knowledge that the people he needs will be there while he is helpless (a sense of basic trust).

2. A fear of loss of approval in the face of disobedience, uncertainty, and non-conformity *versus* a knowledge of propriety and property (independent autonomy) and the feeling that he can assert himself with certainty when and if necessary.

3. The fear of his own magical wishes and the possibility of retaliation for them, *versus* a feeling of sharing and initiative in proper channels in the real world (goal directedness).

As the boy is faced with the father's superiority in reality, he gradually and unconsciously realizes the futility of his quest for the mother, and changes this annihilative identification with the father to a desire to be a big, strong man like the father, but a man without interest or possessiveness in the opposite sex. (Imitative identification—"I only want to be like you.") He attaches his initiative and goal-directness to a sense of industry, fair play, and legitimate competition. We enter the period of latency where the ideal becomes the cowboy who rescues the fair maiden in distress but has no love interest in her. After his conquest of the "bad guy," he valiantly but independently rides off in the dust. He renounces his unconscious love for his mother and, to be safe, gives up all girls as he is afraid of them.

The girl, by the same necessities of fate, passes through similar phases of development. If these

periods in childhood are too disappointing or traumatic, there usually develop extreme feelings of guilt and unworthiness with a generalized, possibly lifelong, inhibition of initiative and competitiveness.

During this period of latency there has been then a decrease in the romantic interest and sexual drive and a great deal of repression of the child's interest in his own body. Children of such ages are frequently embarrassed when examined by a physician and are particularly upset by comparison with grownups.

By eleven to thirteen there is a beginning interest in the opposite sex, but this is usually confined to intellectual discussions of the subject, looking at pornographic literature, and occasionally homosexual play.

Girls tend to acquire a best friend and remain devoted to each other for a couple of years. These crushes are rarely overtly homosexual, and it is infrequent for any sex play to take place. They do spend most of their time together, sharing secrets and discoveries. It seems an important preliminary step to the formation of adult friendships. This is closer than the mother-daughter relationship at any time, and may result in considerable anxiety and envy on the part of the mother. (As this is a necessary part of the turning away from the intense feelings of rivalry associated with family living, reassurance and explanation to the mother and father are frequently indicated.) These friendships tend to break up when one of the girls becomes interested in a boy. Similarly, sororities, one of whose functions is to provide boy friends, frequently lose their members when they succeed in doing so.

With adolescence there is a reactivation of sexuality due to the physiological maturational processes of growth. Interest in the opposite sex reoccurs, initially mostly in fantasy, and may be acted out in the following ways: boys do handsprings, pull girls' hair, and can act mighty insulting; girls get giggly and foolish and attract boys' attention in devious ways. A wise mother knows that when her son begins to brush his hair, wear a tie to school and wash behind his ears, he has fallen in love. Such interest in appearance is a marked contrast with the previous "latency" period.

During latency there has been a series of love affairs with people of the same sex, but as the child progresses into adolescence, he initiates a series of fantasied love affairs with the opposite sex. These are often directed towards older women who either look like or in some way resemble the mother, or older men in some way reminiscent of the father. A teacher, movie star, clergyman, or the like may temporarily become idols to be worshiped. All of these romances are perfectly "safe" because the idol is seldom real or very close. Witness the

continued on next page

formation of crooner clubs where a fragment of clothing or a lock of hair becomes the subject for hours of discussion and envy. It is unwise to exploit the feelings of adolescents concerning these love affairs. Gradually their attention is turned to more realistic, attainable goals and people of more appropriate age. There is much emotion and feeling in such attachments and, as these feelings are now invested in real people, the adolescent experiences deep affect and pain, both in the longed-for union and in the frequently following separation, immortalized by all our popular songs. As life involves multiple separations from people we love, the more such experiences the adolescent has, the more stable his future is likely to be. Then again, if this pattern were to persist through the twenties, you might suspect that the "breaking up" was a defense against the really close relationship that marriage would bring.

Parents usually laugh at the undying devotion of the high school lovers. No sooner have they separated than another situation of equal intensity arises.

If the boy has been overly attached to the mother and is too frightened of her disapproval, which she has unwittingly or wittingly communicated to him, he may see girls as a threat to this union and be unable to pass through these important emancipating experiences. Thus, he has little chance to acquaint himself with feminine psychology and learn what girls are like. Girls may be represented as dirty and exploiting by the mother who desires to keep her son close to her. Fathers with similar problems portray men as beasts and restrict their daughters' activities.

It is natural for both boys and girls to feel the other sex does not understand, and it is through the series of love affairs that they learn the opposite sex is not to be feared. If this does not take place in adolescence and the teenager does not come to regard the opposite sex as a source of his completion with the possibility of offspring to perpetuate the self, he may go into his thirties feeling isolated, lonely, and unable to establish a sense of continuity with what he was as a child and what he had hoped to become as an adult. Such people tend to look upon marriage as a poor obligation and to remain perpetually in a state of adolescence. If marriage is accomplished, there are frequent episodes of running home to mother; and it is at this point that the parent should say, "go back to your home and work it out."

From birth the girl is brighter, more mature, and develops faster than the boy. She complains (particularly at fourteen or fifteen) that the boy is careless, rude and inconsiderate. This seems true, partly because the boy is attempting to show his indifference towards the girl and to avoid the

dangers associated with romance (an unconscious residue from the first period of conflict with his father). This difference tends to diminish through adolescence and, as both boys and girls mature, the boy tends to catch up with the girl; but, sensing her disdain, he goes with younger girls to maintain his superiority.

The height of adolescence is at puberty, and physical types are not clearly apparent until then. Differences in rate of growth cause specific problems. When growth is retarded, there are feelings of inferiority. Those who are tall do not want to associate with shorter ones. Those who deviate in rate of growth may be ostracized, scorned, or accepted as pets. Rate of growth may be so fast that the muscular system cannot keep up with the skeletal, and poor coordination and ungainliness result. The lungs and heart may have trouble keeping up with each other and dyspnea is a not infrequent complaint. The adolescent may become clumsy in one way or another, resulting in embarrassment—in turn creating more clumsiness.

There may be sensitiveness related to over- or under-developed breasts in girls and the appearance of bodily hair and nocturnal emissions in boys. Many personality changes may be noticed at this period.

The onset of menstruation brings its own anxieties which reawaken the fears of mutilation in the girl, as well as a sense of shame and unworthiness.

Erections and masturbation center the boy's interest. Preoccupation upon his genitals frequently takes up considerable of his time and thoughts—to the detriment of his school performance. It is not *what* happens to the teenager, but the meaning of the physiological changes as interpreted by him.

The gap between what the adolescent desires to be and his actual physical development results in fears of helpless impotence and rage reminiscent of earlier days. He often adopts fads, diets, and exercises in order to become a smoother working machine.

Pearson has suggested that there is a greater development of sensory and association pathways during adolescence.⁴ Therefore, there is an increase in perception in fine details and awareness of the beauty and aesthetic values of life as well as an increase in the problems and complexities of earthly matters. Because of this sudden influx of new material and thought, the adolescent takes time to assimilate all that he is learning. Thus, alertness may alternate with apparent stupidity. It is as if there is a resting stage during which these new stimuli are reflected upon and digested. With the increase in sexuality within the self, there is an increased awareness of sexuality outside the self. The child then must consciously and unconsciously face the fact that his parents created him by means

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THE PURPOSES OF THE PROVIDENCE MEDICAL ASSOCIATION*

Presidential Address

FRANCIS H. CHAFEE, M.D.

The Author. *Francis H. Chafee, M.D., President of the Providence Medical Association, 1955.*

ONE YEAR AGO, as your newly elected president, I expressed my deep appreciation for the honor of serving you. And now after a surprisingly brief interval, I have the duty as your retiring president of addressing you upon a subject which our bylaws define as "having special reference to the work and needs of the Association."

Most of us are not conscious of the inner working of our Association. Nor do we consider much whence we have come or whither we are going. The business meeting before each scientific program is short, and we sit through it to hear the more interesting part that is to follow. Even this annual meeting is in many ways something to be endured. I, therefore, believe that our Founding Fathers were wise in requiring this Presidential Address "having special reference to the work and needs of the Association." It provides a time when we can reflect upon the past, and consider our future. To think about ourselves, to criticize our actions and possibly find new goals is occasionally a healthy thing to do.

In pursuing this course I should like to discuss some of the objects of the Association as outlined in the original Constitution adopted on St. Valentine's Day in 1848, and now appearing in Article II of our present instrument. I quote, "The purpose of this Association shall be for the advancement of sound medical science and the promotion of the character, interests and honor of the medical fraternity; for the bringing into one organization the physicians of this district so that by frequent meetings and full and frank interchange of views a harmonious unity of purpose may be achieved."

"The promotion of the character, interests and honor of the medical fraternity."

The standing of this Association in the community is a fitting exemplification of our past success, an attainment which must be jealously guarded by each and every one of us. It is essential that our house be ever policed and in order. Doctor Potter discussed this subject two years ago, and

*Delivered at the 109th Annual Meeting of the Providence Medical Association, at Providence, R. I., January 9, 1956.

I will only add that your officers have acted upon his suggestions. Our vigilance begins with the applicant for membership. He is not aware of the careful scrutiny given his credentials by the Office of the Executive Secretary, but soon after accepting the simple certificate of membership, he recognizes our trust in him to do his part as an active member of this Association. This activity is expressed by practicing his profession with full integrity, by assuming the burden of good community living, and, within our Association, by willingly accepting committee responsibility. This willing response to a request for committee activity is almost automatic, and my friends in other professions tell me that our hours of work so freely given is an unusual and remarkable record.

"The purpose of this Association shall be for the advancement of sound medical science."

Our Program Committee, under the able chairmanship of Doctor Irving Beck, has certainly furthered this precept. The speakers have been well selected and they have delivered excellent papers which we have been privileged to hear. The Committee has done its work well, and we thank them. For by educating us, they have furthered the science of medicine.

The major topic of this address relates to the final clause of the Article, namely, "so that by full and frank interchange of views a harmonious unity of purpose may be achieved."

When I first became a member of this Association, I was told by one of the older physicians that I should deliver a paper at the first opportunity. In doing this, the argument went, I would not only bring knowledge of a new procedure to the members, but would also give the members a chance to know me. It was common in those days for the young member to speak. His enthusiasm was infectious, and we profited from seeing and hearing him. The speaker benefited, for often he was called into consultation at a later date and through the common bond of professional knowledge and the patient, developed an understanding and closer association with his colleagues. Experience was also gained in public speaking. This important art can only be learned through practice, and this platform should provide that training ground, preparing us

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for that opportunity which might come anytime to address a large gathering either within or outside of our profession.

Today it not only has become a rarity for a young member to address us but is becoming uncommon for any of this Association to speak here on a scientific subject. We all know that competent research is being done in this city. It should be reported directly to our members. Why isn't it? One argument that presents itself is the effort in preparing a paper for delivery. The membership is not interested is another. They will not attend meetings unless we have a big-name speaker; they will stay at home. They are tired; there are too many meetings. . . . We all know the arguments.

It is a situation which should be corrected. The local speaker has a definite contribution which should not be denied us. After all, should not the results of local work be first reported here to the members of this Association? We should be interested in the work that our friends and colleagues are doing, and the workers themselves should welcome friendly and constructive criticism. It may be that many are engaged in research which they feel is not "good enough" to publish, but it still should interest our membership, and I repeat, should not be hidden from us. Full and frank interchange of views is not being achieved.

At many of our national meetings it is customary for the speaker to have only ten or at the most fifteen minutes. The information is adequately presented within that period, and I have never heard the criticism that too brief a time was allowed.

Here then is a possible way to resolve our difficulty. The Program Committee, as it has so successfully done in the past, will continue to engage an outstanding speaker for each meeting. The annual meeting will be continued as usual, due to the lengthy business section. But at the six other meetings ten minutes will be saved for a local speaker. There are six hospitals in this city: the Rhode Island, St. Joseph's, the Miriam, the Chapin, the Lying-In and Roger Williams. So each hospital can be responsible for one meeting each year, and on that hospital staff there surely will be individuals competent to speak upon a subject worthy of a presentation.

Here is an opportunity for the young physician to present a paper on some subject, which he may bring from a teaching center, or a discussion of a project in his hospital here in Providence. This paper may be ready for a national journal or meeting; it may be a finished work or a progress report; or only a presentation regarding a planned research. But whatever it is, let us give the young physician an opportunity to be honored in his own country.

Then there would truly be achieved a harmonious unity of purpose. For by learning what others are doing, we will all be better equipped to care for him for whom we most care—the patient.

CONGENITAL HEMOLYTIC ANEMIA ASSOCIATED WITH SPHEROCYTOSIS

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The treatment of this disease is very simple; the spleen should be removed. At the time of surgery it is important to look for and remove any accessory splenic material. This is the only hemolytic disease in which splenectomy is almost 100% effective.^{19 20 21} Splenectomy should rarely be performed in crisis.²² The patient should first be prepared by transfusion, if necessary, cautiously administered²³ and surgery done as an elective procedure. Following splenectomy, no further crises occur.²⁴

The four cases now presented are those of a white male, age 34, and his three children, who are now six, seven, and nine years old respectively. Another child age one and a half has been followed since birth. As yet he has shown no clinical evidence of the disease and does not have an enlarged spleen. His Hgb is 10.8Gms, an osmotic fragility is positive, the stained blood smear shows moderate spherocytosis, the serum bilirubin is 0.4 mg. total, and the Coombs Test is negative.

A fifth child, a girl, was born October 16, 1955. Tests done on her four days after birth showed: Coombs Test—negative, Hgb. 22 Gms, and the osmotic fragility increased.

The first case came to my attention in June, 1953, when one of the children was first examined because of bed wetting for a month. His past history was significant in that he was said to have been jaundiced for two weeks at the age of one year. Subsequent to this his urine was occasionally dark brown. The family history disclosed that in 1951 the father had been admitted to another hospital for cholecystectomy. Pre-operative workup showed increased red cell fragility associated with splenomegaly. He underwent splenectomy and was discharged with a diagnosis of congenital hemolytic anemia, type not specified. The gall bladder was removed at a later date. Examination of this first child revealed a spleen enlarged to three fingers below the costal margin and a hemoglobin of 8.5 gms. Further studies revealed spherocytes in the stained smear and an increased osmotic fragility. Splenectomy was done on the child in July, 1953.

Splenomegaly did not appear in the third and fourth cases of this group until the summer of 1954. Laboratory examination confirmed the diagnosis of congenital hemolytic anemia with spherocytosis. Splenectomy was done in these two cases

in October 1954. From the clinical and hematologic viewpoint all three children have benefited from surgery.

A considerable amount of laboratory work has been done in these cases, but in order to conserve time I will not report the data here. It is interesting, however, to point out that some of these cases post-operatively show a marked rise in the platelet count. Our first case, on the seventh post-operative day had a platelet count of 988,000. This raises the question of anticoagulant therapy for the prevention of thrombosis. Anticoagulants were not used in any of our cases and there were no thrombotic or embolic complications.

Subsequent to splenectomy all three children have done well. Tests done one week ago showed hemoglobin levels of 13.3; 12.6; 13.5 gms respectively.

SUMMARY

The etiology, diagnosis and treatment of congenital hemolytic anemia associated with spherocytosis have been discussed. Four cases, Mr. F. and his three children have been shown to have the disease and have undergone splenectomy. Two additional children are known to have the disease. Splenectomy will be done as soon as the parents grant permission.

Acknowledgment is made to Orland F. Smith, M.D., chief of surgery, and Gary P. Paparo, pathologist, of Memorial Hospital, who were associated with the author in the diagnosis and treatment of these cases.

A complete bibliography is available for this article, upon request.

THE CROSSROADS OF ADOLESCENCE

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of the sexual act. He views them in terms of the values he has learned to associate with his own sexuality and with his parents' attitudes towards such activities in others. This frequently results in extreme inner turmoil and a devaluation of the parents with a turning away from them to outside ideals, frequently asexual figures. Children in the sixth, seventh and eighth grades often do poorly in school, become behavior problems to some degree, and are extremely sensitive to the problems of the origins of life and the purpose of living. As they ponder in this way, it is difficult to live with them. They fidget, giggle or become very hard boiled. Their desire for ideal people irritates their parents.

American culture with its many differing opinions requires the adolescent to make up his mind about many crucial things. He must decide that he is basically a man, love a woman, and pattern himself accordingly. He may, however, take as an ideal someone of different faith or political belief and psychologically swallow this person whole. It may

be that the need to find a role and a stamp is so great that the youth may adopt a negative identity (patterning himself after the toughies, gangsters, etc.) rather than none at all. Thus it may happen when parents are sometimes preoccupied with avoiding the repetition of a particular trait in a child ("a good-for-nothing drunkard like Uncle Bob") they find that, because of the lack of an energetic positive ideal, they have unwittingly produced that which they feared most.

During the adolescent process the child temporarily identifies himself with various people, copying their way of dress, mannerisms and habits. Even though some of these identifications may seem undesirable at the time, they are necessary wayside stations, at which a testing-out process can be experimented upon. Here the important thing is what lessons have been learned, and it is to the family's best interest to permit a wide experience from which the teenager can reach his own conclusions and make his own decisions. The acceptance or rejection of the family's set of values has already taken place and was dependent upon whether the child felt all along that he was an integral part of the family. It would be wiser to rely upon the basic sense of worth and positive family identifications that have been established prior to this period than to engage in a struggle that usually results in either abject surrender or a state of continuous tension or violent rebellion. We cannot predict changes in our culture because of the tendency of the teenager to try new things, be different, and find an identity distinct from his parents. This is not to say that parents by their example and discussion do not and cannot exert considerable influence during this time.

The parent-adolescent relationship is further complicated by the greater or lesser degree of competition between the up-and-coming teenager and the "declining" (in his eyes) parents. A stormy (though not necessarily delinquent) adolescence is a frequent precursor of a healthy maturity. Great theoretical arguments are likely to do nothing more than fixate identifications which might otherwise have been only temporary stops along the way.

In the teenagers' struggle with the older age group, they tend to seek solidarity in gangs that can be found in drug stores, fraternities, sororities, etc. This group identification is extremely appealing to the youngster and gives him a sense of strength. We see, during this revolt against the parents, many alliances to religious or political groups that are extremely right or left of center and that in no way reflect the future convictions and beliefs of the individual when his needs to conform begin to outweigh his needs to rebel.

Opportunities to meet in surroundings conducive to the establishment of ideals acceptable to the par-

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DISEASES DANGEROUS TO CURE*

A Treatise by Raymond, 1757

FRANCESCO RONCHESI, M.D.

The Author. *Francesco Ronchese, M.D., of Providence, Rhode Island. Associate Professor of Clinical Dermatology, Boston University School of Medicine.*

THE DATE of Raymond's birth is not known. He lived in Marseille for many years, after studying in Montpellier, where he was dean of the medical faculty of the University of Montpellier, general treasurer of France and a King's pensioner.

He published his treatise after fifty years of practice. After his death in 1765 it was reprinted twice by Giraudy. Dezeimeris's dictionary, 1836, says: "The people are still interested in his work. His explanations have lost their value, but the facts remain and they are numerous."

The national library of Paris does not own the first edition, nor is the treatise in the British Museum or the Library of Congress.

The work is little known as proved by the fact that it is not quoted in a recent historical study of Schönfeld.¹ The conception, such as the one expounded by Raymond, had forerunners, and followers, but, as far as I know, there is nothing in textbook form with a title indicating special diseases one is warned against trying to cure, or else suffer dire consequences, even death.

Just as Boorde² wrote at the beginning of the sixteenth century that every one must have good nails to scratch the skin and make the flesh weep of rotten blood, and also warned against the use of ointments which make the disease move inside, so Raymond forbade external medication and bled his patients white.

As a dermatologist I was naturally interested in the book when I glanced at the index, listing as topics: skin eruptions, disorders of the sweating, scabies, darts, ringworm, ulcers, etc. The second volume deals with the following topics: hemorrhages, vomits, diarrhea, leukorrhea, gout and fevers.

Reading Raymond one receives the impression that healing a chronic ulcer or a chronic dermatosis

was a trifle. The real difficulty was to prevent the healing of a disease. It looked as though there were not such a thing as a recalcitrant dermatosis in Raymond's time. It has been often said that the practice of dermatology would be extremely pleasant if it weren't for infantile eczema. According to Raymond the physician was to congratulate the mother for having a son with atopic eczema and warn her against having it cured. He was to congratulate the patient for his beautiful psoriasis or his deep stasis ulcer for which he would live to a happy ripe old age. Beware of curing them. *Noli me tangere*. Convulsions and rapid death could follow.

The present day layman would not accept such talk. He takes the risk and prefers to have the psoriasis cured. Perhaps he would insinuate that the warnings were an excuse to cover the physician's shortcomings. Patients of two hundred years ago would never have dared to argue with the semi-divine personality of the physician.

A passage of the preface gives the general conception of the thesis which Raymond dilutes in 768 pages: "What a wisdom . . . one must have to establish if a disorder or a symptom is good or bad and consequently if it must be stopped or be left alone. Especially the fair sex will cry: 'According to your concepts we will be condemned to keep our darts, pimples, pustules and everything marring the sweetness, the beauty of our skin.' Never attack with external remedies. Often the best treatment is no treatment (a perfectly acceptable idea)."

Raymond describes a beneficial (although annoying) perspiration, which must not be stopped, especially with external remedies (he is a forerunner of the present ideas of poral occlusion as a cause of dermatosis and of itching) the penalty for the stoppage being colics, diarrhea, fever, cough, hemorrhages, convulsions.

He quotes a case from Lusitanus of a man sweating for ten years. He tried to stop it in a cold water bath and was dead three hours later. Another case was a nun with feet hyperhidrosis. She used alum soaks and the hyperhidrosis stopped, but epilepsy, fever, consumption and death followed.

Children are subject to a dermatosis especially in summer when they sweat. For this disease there

*Read at the XIVth International Congress of History of Medicine, Rome and Salerno, September 13, 1954, and at the '34 Medical Club, Providence, Rhode Island, October 10, 1955.

is no French name, but the Latins call it *sudamina* and the Greeks have a word for it, *hidroa*. It is due to poral occlusion.

Raymond relates the case of an officer suffering from *gale* (the modern French name for scabies) due to food, cured with ointments, but followed immediately by vomits, hiccups, insomnia. Another case was a fourteen-year-old girl in perfect health, except for *la gale*. An ointment was applied, *la gale* disappeared but was replaced by fever. Raymond's remedy: put the patient in bed with a *galeux* or make him wear his shirt.

After reporting many similar cases, Raymond says that the accidents such as vomits, hiccups, fevers, were due to the *gale* which entered the body. To cure said vomits, hiccups, fevers the only thing one has to do is to recall the rash to the cutaneous surface. He warns against external remedies as being good only to lock the wolf into the stable.

Maybe Raymond interpreted to his own advantage Dante's passage: *E lascia pur grattar dov' è la rogna*. (Par. XVII)* Remedies recommended for the kind of *gale* that must be cured are: one or more bleedings, according to age, broth, purgatives, donkey's milk, etc.

The third chapter is on *les dartres*, a name very popular in the French dermatologic literature up to 1900, then completely abandoned for unknown reasons.³ It corresponded approximately to the present day vague conception of eczema and eczematoid conditions.

Raymond asks himself (and this question can be asked today and may remain unanswered) why this pathologic lymph running through the entire body, and consequently in contact with the entire cutaneous surface produces only small islands of dermatitis? Raymond does not hesitate to say that this is due to the fact that the lymph runs in certain vessels and not in others, or that certain body areas have a special humoral disposition which allow the rotten humor to concentrate in that area in preference to another (a perfectly acceptable idea).

We are still at a loss to explain why a keloid may develop after electrocoagulation of a mole, while another mole removed in an identical manner and located only a few centimeters away heals with a perfect scar; why the same kind of garters produce a contact dermatitis in one leg and not in the other; why the leather strap of a wristwatch may produce a dermatitis on one wrist and not on the other.

*And where the itch is let the scratching be (Langdon's translation). Dante of course, was not discussing a physical itch. *Rogna* is the Italian vernacular for our scabies. Today, as in Dante's time it may be used both with a physical and moral meaning. In Dante's and Raymond's times, the *acarus* had not been discovered yet, and the Italian *rogna* or *scabies*, and French *gale* and *dartre*, meant any eczematoid dermatosis, parasitic, non-parasitic and . . . psychomatic.

At page 155 Raymond returns to the attack of external remedies. A man was suffering for years from a *dartre* on a finger. Somebody gave him an ointment which cured the *dartre* in one day. Two days later he developed fever, thirst and a torrent of serum running from the face as if he had been burned with fire. In another case, serious consequences followed the cure of a *dartre* on a knee. A vesicatory was applied to the same knee, the *dartre* recurred and the general health was re-established.

The practice of using vesicatories as a remedy for various diseases including skin diseases is still practiced, according to Schönfeld.¹

The fifth chapter deals with chronic ulcers provided by nature, as a natural sewer, to liberate us of bad humors. Its cure may mean a long and serious sickness. If it closes by itself it is better to open one artificially.

In the chapter on hemorrhages Raymond says that the blood has been thought of as essential for health and life. It is not surprising if ignorant physicians are opposed to bleeding, a method which has been recognized for centuries all over the world for its beneficial effects. Raymond says that there is no foundation to the belief that one may die from it.

In regard to sweating of blood, he says he saw a case himself. All physicians agree today (1757) that the menstrual flux is due to lack of sweating

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TRAITE DES MALADIES QU'IL EST DANGEREUX DE GUÉRIR.

OUVRAGE

UTILE ET NECESSAIRE AUX MEDECINS,
ET AUX PERSONNES SUJETTES A DES IN-
COMMODITES HABITUELLES. AVEC DIX
OBSERVATIONS NOUVELLES, ET
INTERESSANTES.

PAR Mr. DOMINIQUE RAYMOND, Docteur en
Médecine de la Faculté de Montpellier,
Doyen de l'Aggrégation de Marseille, Pen-
sionnaire du Roi, Président Trésorier gé-
néral de France.

Agrescitur medendo . . . Esoid. Lib. XII.

TOME PREMIER.



A AVIGNON,
Chez F. B. MERANDE, Imprimeur-Lib.
près la Poste.

M. DCC. LVII.

Title page of the first volume of Raymond's treatise.

and to the sedentary life of the woman and consequent accumulation of humors at the end of the month. Genital hemorrhages in advanced age are not dangerous and medical interference is necessary only when they stop. There are feminine and delicate men, who, doing very little exercise, sweat little, and accumulate blood like a woman. They will bleed monthly from the nose, the mouth, in the urine or from the rectum.

In the second volume Raymond discusses the morning vomiting of saliva, water and humors, which he calls habitual or common, like the habit of a morning bowel movement. For this condition too, he is against stopping it, and relates cases in which patients stopped tickling their throat in the morning and fell seriously sick, recovering as soon as the practice of vomiting in the morning was resumed.

He, then, discusses diarrhea. One type he calls spontaneous or idiopathic, different from a dozen others. There are individuals who, to have their bowel movement, have only to make a few steps on a cold and damp pavement. It is well known that cold closes the pores and pushes the sweat back inside. The sweat goes in the intestine and the diarrhea is produced. This confirms the close relation between skin and intestine, and the truth of the aphorism: *cutis raritas, alvi densitas*, and *alvi raritas, cutis densitas*. Black stools from severe intestinal hemorrhages make no impression on Raymond. As for stopping a diarrhea or an intestinal hemorrhage, convulsions and death may result.

The fourth chapter of the second volume is dedi-

cated to leukorrhea. It is well known that the womb is the sewer through which passes all excesses like the heavy monthly burden of the womb. From where does leukorrhea come? From the womb, the neck or the vagina? From all three. Stopping leukorrhea may be followed by diabetes. Women would be subject to gout, as well as men, if it weren't for the womb acting like a sewer and protecting them against this distressing disease.

The beneficial effects of fever is discussed (see again Schönfeld¹) in a present day writer manner.

In closing, Raymond says that he tried to demonstrate that there are diseases which one must not be afraid of and the course of which must not be interrupted.

SUMMARY

Raymond, in 1757, published two volumes of 384 pages each, discussing the thesis that there are certain diseases with which the physician should not interfere. No attempt should be made to cure them, under penalty of most serious consequences. The work enjoyed great popularity, proved by two editions after the author's death. It is an historic curiosity and a bibliophilic rarity.

However, methods advocated by Raymond are still in use. Poral occlusion concept as a cause of dermatoses is just as good now, as is fever therapy. Diseases called idiopathic by Raymond are still called idiopathic.

The thesis is supported by a long list of cases in which patients met a rapid and convulsive death from the closing of an ulcer, spontaneously or by art, the clearing of a skin eruption, the discontinuance of morning vomiting, the stoppage of great hemorrhages, of chronic diarrhea, or of leukorrhea.

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Owned and Published Monthly by the Rhode Island Medical Society
 106 Francis Street, Providence, Rhode Island

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GRIEVANCE COMMITTEES

ONE OF THE major actions taken by the House of Delegates of the American Medical Association at its clinical session in Boston was the adoption of a committee report which sets up guides for grievance or mediation committees within medicine on a national basis.

The Rhode Island Medical Society has had a committee on medical grievance for at least twenty-five years, while the Providence Medical Association, largest component district association of the Society, has had a committee on ethics and deportment for equally as long a time.

In its study of the problem nationally the A.M.A. committee discovered that there was a wide variation in the methods of organization and operation of grievance committees and that there was need for clarification and definition to eliminate confusion on the part of the profession and the public.

Therefore the report maintained that the complete objectives of such committees can be attained only when there is proper organization and operation of the committee, and when it is empowered by the constituent association not only to receive complaints, but also to investigate, mediate, arbitrate, and where necessary, refer them to appropriate bodies for adjudication.

The Providence Medical Association has taken the step recommended by the A.M.A. committee by revising its bylaws to create a grievance committee of five members with full authority to act on all cases, and with the right to report its findings, with recommendations, to the Executive Committee when it feels that disciplinary action may be warranted for violation of any of the rules of the Association, or for conduct found to be detrimental to the best interests of the medical profession.

The other district medical associations in the state have their committees on ethics or grievance, although in most instances major problems are referred to the committee on grievance of the state medical society. It would appear that each district society might emulate the example of the Providence association by amending its bylaws, if necessary, to guarantee that the local grievance committee shall have the necessary constitutional authority to act quickly and effectively in resolving all complaints involving physician-patient relationships.

The national study indicated that less than three per cent of the doctors are complained against, and most of the complaints involve fees. It would be to the advantage of every physician to have a clear

continued on next page

understanding with his patients regarding the charges for services rendered, and insofar as possible in advance of rendering the services.

The grievance committee is the one group of the Society that we would like to have transact the least amount of work in any given year. You—the individual member of the Society—can contribute much to the elimination of work for this committee.

SURGEONS' HALL OF FAME

In recent years impetus has been given to historical shrines, with sports heroes in particular being enshrined in various halls of fame. Thus baseball has its monument at Cooperstown, New York, and football at New Brunswick, New Jersey.

The world's medical heroes are many, and in various ways they have been honored through the centuries in their local areas, and possibly in many foreign lands. Within the past year, however, the International College of Surgeons has established a museum on Lake Shore Drive in Chicago where the immortals of surgery will be displayed by life-sized statues sculptured in stone and mounted on marble bases. The statues are the work of Edouard Chassaing and Louis Linck of the Chicago Art Institute and will comprise thirteen sculptures.

Of particular interest to Rhode Island is the fact that these statues for surgery's hall of immortals are a contribution to the College by Mr. and Mrs. Edwin Speidel of Providence. Mr. Speidel, a truly remarkable man, is head of both the Speidel Corporation which engages in the manufacture of jewelry, and also president of the Desitin Chemical Company, one of the fastest growing pharmaceutical companies in the country.

We are particularly proud that Rhode Islanders have been responsible for perpetuating so vividly such renowned scientists as Imhotep, the earliest known physician (*circa* 2700 B.C.), Hippocrates, father of medicine; Galen, who pioneered in experimental physiology; Ambrose Pare, father of modern surgery; Andreas Vesalius, famous anatomist; William Harvey, discoverer of blood circulation; Giovanni Morgagni, father of pathological anatomy; Mme. Marie Curie, discoverer of radium; Louis Pasteur, discoverer of rabies prevention; Ignaz Semmelweis, true pioneer in antiseptics for puerperal fever, and obstetrics; William T. G. Morton, father of anesthesia; Joseph Lister, famed for work in surgical antiseptics, and William C. Roentgen, discoverer of the roentgen ray.

PROFESSIONAL EDUCATION FOR WOMEN

For the sixth consecutive year the medical school enrollment for the 1954-55 period established a new record. The recent DENTAL STUDENTS REGISTER published by the American Dental Association

indicates that more young men and women are studying to be dentists than ever before. But in the field of professional nursing we find repeated warnings regarding the nursing shortages.

The report on medical education issued by the Council on Medical Education of the A.M.A. for 1954-55 lists 30,411 male students and 1,761 women students in the medical schools of the United States and Canada. The women enrollment is slightly greater than the previous year. Excluding Women's Medical College, medical schools of three universities enrolled forty or more women, and in four schools women accounted for ten per cent or more of the total enrollment.

Dentistry has not attracted women, but the auxiliary profession of dental hygienist has shown a steady growth in the past four years. The DENTAL STUDENTS REGISTER reports an enrollment from 1,454 in 1951 to a new high of 2,009 in 1955.

Meanwhile the number of graduate nurses has increased more than the population increase, but the shorter work week, more "outside" job opportunities and the greater variety in nursing activities, has created an apparent shortage of graduate nurses. Undoubtedly if nurses were limited to actual nursing duties and relieved of responsibilities for clerical, housekeeping, dietary and administrative activities, the demand for nurses for patient services and care would be adequately met. In this connection it is to be noted that there has been an increasing development in the training under an organized program of practical nurses to relieve the graduate nurse of some of her relatively minor assignments.

TIMELY BOOK REVIEWS

The RHODE ISLAND MEDICAL JOURNAL is proud of their book reviews, chiefly because we think they are so well done, but also because we realize that we are helping out the Medical Library by our careful work with them. For years it has been recognized in the Society that the MEDICAL JOURNAL, with its reviews, and the Library, with its books, have had a valuable cooperation. In fact, once it was suggested that our MEDICAL JOURNAL be discontinued and that we use the NEW ENGLAND JOURNAL OF MEDICINE as our official publication. The NEW ENGLAND JOURNAL is one of the outstanding ones of the world and an affiliation with them could be a valuable thing. One of the greatest arguments that was used for our keeping our individuality was the fact that we get great value from the books we receive for review.

Not too many years ago, through a mistake in their home office, one of the largest book publishers got the impression that we were not doing a good job with their books. We did not simply

reassure them that we were. Mrs. DeJong, our Librarian, with a good deal of trouble, looked up the books we received from this publisher over a number of years, and also looked up the reviews. It was easy to convince them that we had been doing good work. Through some inadvertence in their home office, the editor had been misinformed about the whole matter.

We are pretty careful as to whom we give a book for review. A member who is asked to do this has had to prove his worth before we go near him. It requires a good deal of thought sometimes as to just where we will send a book for review, and we feel that we are paying a decided compliment to any doctor whom we ask to review a book.

One of the most important things about book reviewing is timeliness. We rather feel that a publisher wants his reviews in to start the sales quickly. A lapse of a year or two between publication and reviewing is much to be regretted. Therefore, we try to keep after our reviewers in order that they do not procrastinate.

Most of our reviews come in promptly, but that is not always the case. We hope that you will all cooperate with us in this matter.

SPARE THAT CORTISONE

Perhaps you will decide that we "say an undisputed thing in such a solemn way," but it is an important matter that ought to be harped upon. First let us remark that cortisone is a tremendously important medicine, that cannot be over-emphasized. But like about everything in this world it has limitations and such limitations should be strongly emphasized. Here are a few examples pertaining to this matter.

At the Rhode Island Hospital a short time ago a rather simple appendectomy suddenly resulted in the patient going into extreme shock.

Within a week one of our brightest physicians got an emergency call from a surgical friend in Boston who appreciated his great abilities. The Bostonian had just taken part in an operation in which the patient unexpectedly, and for no good reason that they could see, went into extreme shock.

Last year we called upon a friend who had just had his prostate removed. Everything had gone swimmingly and he told us he would be leaving the hospital in a day or so. We came back three weeks later to find that he had just left the hospital. When we asked his wife what had happened, she replied "It is something about some medicine."

The same thing occurred in all these three cases. The patient had previously been treated with cortisone and his surgeons had not known of this matter. In the first two cases the results came near to being the death of the patients. In the third case

it was a mere matter of edema of the tissues, delayed healing of the incision, and the expense of about three weeks extra stay at the high-priced hospital room. All three cases finally resulted happily. Lots of such cases don't.

The urticaria, pruritus, and other disagreeable things which so frequently follow the use of antibiotics are often treated now with the quick-acting cortisone. So there must be a great many people in the community now who have had cortisone. One of these cases which we happened to know of after long suffering with his urticaria etc., had been put upon cortisone with some excellent quick results. Unfortunately he found shortly after that he could no longer carry out all of his marital functions. He was not at all happy about the results.

We have two conclusions to draw from this *Comedy of Errors*. There has long been a folk saying in New England, "Don't send a boy to do a man's errand." It is likewise often important that an able-bodied man should not be sent to do a small boy's job. We have a feeling that many of the uses of cortisone are examples of this last error. It is recognized now that a goodly proportion of arthritis cases are handled with as good results in the long run by the use of aspirin as by cortisone. Of course the practitioner has to cater somewhat to the demands of his patients. These patients who are pretty apt to be impatient are often not going to go slowly along with an aspirin when they know that Mrs. Jones across the street was relieved of her discomfort in a few days with the use of cortisone. So there is bound to be an overuse of cortisone. However, it cannot be too much emphasized that patients who have cortisone should be well aware of the fact and also aware of the fact that later on, should they meet with serious emergencies, it is exceedingly important that their new medical helpers should understand that they are dealing with a tricky situation.

POISON INFORMATION CENTER

With the realization that many lives might be saved, and much suffering averted by prompt treatment of patients with acute poisoning, the American Academy of Pediatrics, through its Accident Prevention Committee, has published a manual titled *ACCIDENTAL POISONING IN CHILDHOOD*. In addition, the Massachusetts Chapter of the Academy, with the cooperation of the state department of health, and other agencies, have created a **POISON INFORMATION CENTER** located at the *Children's Medical Center, Boston*. The telephone is BEacon 2-2120.

Information as to antidotes for the treatment of new and little known toxic substances can be obtained through this Center. Physicians should note this service which is available to them and through them to their patients.

CLINICOPATHOLOGICAL CONFERENCE

At Woonsocket Hospital, September 10, 1955

Presented by FRANCIS J. KING, M.D., *Chief of Surgery*, AND EDWARD B. MEDOFF, M.D.*Discussion by* ROBERT W. RIEMER, M.D., *Assistant Surgeon*, Rhode Island and Pawtucket Memorial Hospitals

A SIXTY-SEVEN-YEAR-OLD white, retired salesman was admitted to the Woonsocket Hospital on July 19, 1955.

Family History: Father died in Syria—at unknown age and from unknown cause. Mother died at age ninety in Syria—? cause. One brother died at seventy-six—cardiac. One died—forty—appendicitis. One died in Syria—? cause. One sister—living and well—in Syria.

Marital History: Eight children living and well. Wife living and well.

Chief Complaint: Sudden, severe sharp pain in the left groin—about one and one-half hours' duration.

Present Illness: This patient felt well until this morning. He had walked to a neighbor's to buy some goat cheese. He was standing in the room waiting for the neighbor to get the cheese at about 1:00 P.M. when he felt this sudden pain in his left groin. He dropped to his knees and said that a lump appeared in the groin, at once, which could not be pushed back. He became a little sweaty and a little shocky. A doctor was called who, unable to reduce the lump, gave him 75 mgs. of Demerol and sent him into the hospital. Blood Pressure 90/50. (L.M.D. says blood pressure always 100-105 systolic.)

Systemic History: Absolutely normal.

Past History: Twenty years ago he had pleurisy. Six or seven years ago he had a similar lump which disappeared on pressure.

Six years ago he had what was called a coronary attack and was kept quiet for six weeks.

Physical Examination: The patient was admitted with a diagnosis of strangulated inguinal hernia. Five feet-six inches tall; weight 195. No loss. Temperature 97. Pulse 80—regular. Respirations 20—regular. Blood Pressure 105/80. Nutrition: well-developed, elderly male, swarthy color, slightly apprehensive.

The physical examination was negative except for a small, hard, tender mass about the size of an ordinary hen's egg over the left external inguinal ring. This mass could not be reduced.

Operation: This patient was operated on about 3:00 P.M., July 19, 1955. At operation a dark bluish, edematous mass was found protruding through the external inguinal ring within the cord. On removal this proved to be preperitoneal fat. No sac could be identified. Below the internal ring the fat was infiltrated with reddish blood. There was no hemorrhage. A herniorrhaphy was done. The patient's condition became unsatisfactory during the operation and he was given one unit of Expandex. He had already had about 500 cc. of 1% Procaine slowly, intravenously, during the operation. He was given an additional 500 cc. of normal saline. Immediately post-operatively he was given 500 cc. of citrated blood. His blood pressure during the operation had been running along about 100 to 105 over 80. It dropped to 60/40 with profuse perspiration.

Laboratory Data: His initial blood count was:
 R.B.C. 3.36 W.B.C. 10.9 Hemoglobin 68%
 Stabs Segments Lymphocytes
 2 70 28

Urinalysis: (catheter specimen) Gravity 1.024 + 1 albumin. No sugar, WBC Sediment 8-14, RBC 30-40 per hpf, occasional hyaline, leucocytic and granular casts.

Progress: After return from surgery the patient had a sudden weak spell. His blood pressure dropped to 65/40. He was given 100 mgs. of Solu Cortef intravenously and the blood pressure rose to 120. During the first postoperative night there was some vomiting. A Levine tube was put down next morning but very little fluid obtained. The tube was removed at 8:30 P.M. On the day following operation, there was mild soft distention. On the twenty-first, he had an excellent result from a saline enema, both flatus and fecal. The blood picture on the day following operation was: R.B.C. 2.88, W.B.C. 17, Hemoglobin 51%, Chemistry—N.P.N. 44.5, Blood Sugar 190 (I.V. g/s).

He was given 500 cc. of citrated blood.

The blood picture on the twenty-first was—R.B.C. 2.38, W.B.C. 21.6, Hemoglobin 46%.

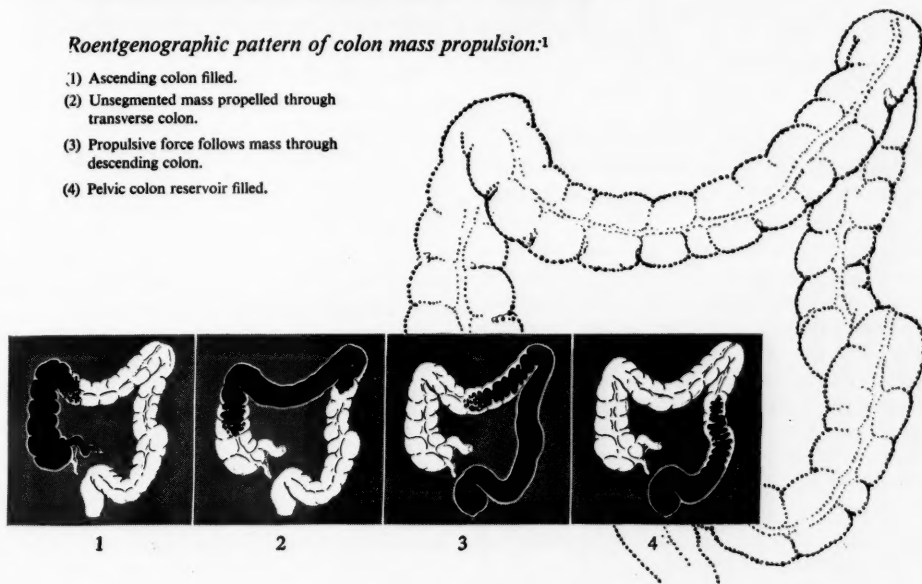
He was put in an oxygen tent with some relief.

continued on page 96

SMOOTHAGE ACTION IN CONSTIPATION

*Roentgenographic pattern of colon mass propulsion:*¹

- (1) Ascending colon filled.
- (2) Unsegmented mass propelled through transverse colon.
- (3) Propulsive force follows mass through descending colon.
- (4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil®

*Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.*²

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of *Plantago ovata*) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.³

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it de-

mands adequate intake of fluids (one glass with Metamucil powder, one glass after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. G. D. Searle & Co., Research in the Service of Medicine.

1. Best, C. H., and Taylor, N. B.: *The Physiological Basis of Medical Practice: A Text in Applied Physiology*, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.
2. Bargen, J. A.: *A Method of Improving Function of the Bowel*, *Gastroenterology* 13:275 (Oct.) 1949.

SEARLE

CLINICOPATHOLOGICAL CONFERENCE

continued from page 94

He had another transfusion and on 7/22, R.B.C. 2.81, W.B.C. 24.8, Hemoglobin 54%.

Blood Sodium 130.2. Potassium 3.55.

On 7/23, Blood picture—R.B.C. 2.25, W.B.C. 19, Hemoglobin 43%.

On 7/22, the patient had spells of cyanosis with distress although his blood pressure remained about 120/70.

The patient had been seen by Doctor Frank Vose on the nineteenth and again on the twenty-second. A comparison of EKG's showed no evidence of recent myocardial damage.

On the third postoperative day, the abdomen was moderately distended with no palpable mass or rigidity. Active peristalsis. Pulse 120—regular. It was noticed that the left foot felt warmer than the right. Pulsation was felt in both femoral, popliteal and dorsal pedis arteries. The rapidly falling hemoglobin, in spite of transfusions, and with postoperative shock indicated blood loss which must have been extraperitoneal as there was no evidence of bleeding or melena.

On July 23, the patient had a poor night. The abdomen was distended, hard and dull in the left flank. He expired at 12:05 P.M.

Discussion

Robert W. Riemer, M.D., Assistant Surgeon,
Rhode Island Hospital and Pawtucket Memorial Hospital

This is the history of a sixty-seven-year-old Syrian who was well up until 1:00 P.M. the day of his hospitalization when he was seized with left groin pain accompanied by a mass. He was immediately taken to the hospital where a left inguinal herniorrhaphy was performed for a strangulated hernia two hours after the onset of his illness. At operation no strangulated bowel was found; although we can not be sure as no definite sac was found and the peritoneal cavity was not entered. His condition deteriorated rapidly during the operation, manifested by peripheral vascular collapse necessitating whole blood transfusions and plasma expanders to maintain his blood pressure. He died on his fourth postoperative day, never having recovered from his original illness. His postoperative course was one of shock from hemorrhage manifested by a falling hemoglobin, a rapid pulse and a falling blood pressure in spite of whole blood transfusions and Cortisone intravenously.

I feel this patient suffered a vascular accident; probably a ruptured abdominal aneurysm into the retroperitoneal space. Hernias, especially inguinal, are notorious in presenting themselves when there is acute abdominal pathology present. They are the "Red Herrings." I will never forget the acute left

inguinal hernia that I operated upon and found an inguinal sac filled with pus as a result of a generalized peritonitis from a ruptured appendix, nor of the right inguinal hernia that was operated upon as an emergency where a traumatic ruptured small bowel with its associated peritonitis was found. Inguinal hernias are not infrequently the presenting signs of lung cancer.

This man first experienced pain, then followed by swelling which is reverse of the usual findings in strangulated or incarcerated inguinal hernias. It would be unusual to have the findings of strangulation with associated gangrene of the bowel taking place so rapidly; namely, in a matter of two hours. Therefore, I feel, even though the peritoneal cavity was not opened we can eliminate strangulated inguinal hernia with its associated intestinal gangrene as a cause of this patient's illness.

Another vascular accident that might be considered is that of mesenteric thrombosis with resulting gangrene of the bowel. This condition usually manifests itself as a closed-loop-bowel type of obstruction with the associated gangrene with marked abdominal distention and associated vomiting, severe abdominal pain, central in origin, and associated spasm. Coffee-ground material will be vomited and there will be blood in the stools. The N.P.N. will frequently be elevated due to the large amount of blood in the intestinal tract. This man's N.P.N. was only 44. He had very little abdominal distention and little vomiting.

Thus, we are left with a vascular accident where there is constant blood loss with associated shock. This man's condition could essentially fit the picture of a slowly bleeding, or dissecting, aneurysm in the retroperitoneal space. When the aneurysm ruptures into the peritoneal space, or a portion of the gastrointestinal tract, it is usually massive and of short duration. Since this man lived for four days and had few abdominal findings indicative of peritoneal irritation, I feel this man's aneurysm ruptured retroperitoneally. Although this man was comparatively healthy, he had manifestations of arterial disease by having had a coronary six years ago.

It is interesting that one-half of the patients with abdominal aneurysm have no symptoms. When pain occurs it is not localized. Physical examination will pick up a lateral, expanding, pulsating abdominal mass. X rays may pick up abdominal aneurysms due to the calcification of the wall. Many of the cases will present themselves as acute surgical abdomens from the rupture of the aneurysm intraperitoneally. Abdominal aneurysms tend to dissect distally and are limited proximally by the renal arteries. The length of life of patients with abdominal aneurysms, after they have been dis-

concluded on page 98

the key to / **higher analgesic potency**

In a clinical evaluation of S.K.F.'s relatively new, non-narcotic analgesic —'Daprisal'—it was found that "mood elevation obviously was the key to the heightened analgesic potency of the preparation."

In summing up, the investigator reported that three points were "particularly clear: (1) the analgesic efficacy of the preparation was at least equal—if not superior—to that of aspirin-phenacetin-caffeine-codeine; (2) side effects—when they did occur—were mild; (3) a definite sense of well-being was observed in the majority of patients treated."

He concluded that "the first two points alone would make 'Daprisal', as a non-narcotic, preferable to any preparation containing codeine. The third point constitutes a definite therapeutic 'bonus' since there are few clinical conditions which are not benefited by an improvement in the mood of the patient."

Hanes, C.B.: Am. Pract. & Dig. Treat. 6:602, 1955.

Try 'Daprisal' in such conditions as chronic headache, low back pain, arthritis, traumatic pain. You will find it a very useful agent—especially when the pain is moderately severe.

DAPRISAL*

*It contains the mood-elevating components of
Dexamyl* and two highly effective analgesics*

Smith, Kline & French Laboratories, Philadelphia

Formula: Each 'Daprisal' tablet contains Dexedrine* Sulfate (dextro-amphetamine sulfate, S.K.F.), 5 mg.; amobarbital, $\frac{1}{2}$ gr. (32 mg.); acetylsalicylic acid, $2\frac{1}{2}$ gr. (0.16 Gm.); phenacetin, $2\frac{1}{2}$ gr. (0.16 Gm.). 'Daprisal' is available, on prescription only, in bottles of 50.

*T.M. Reg. U.S. Pat. Off.

CLINICOPATHOLOGICAL CONFERENCE

concluded from page 96

covered, is usually nine months; and approximately one month, once the patient has been hospitalized.

It is peculiar how a disease seems to identify itself when looked at through the "retrospectroscope." Here we have the opportunity of seeing the disease for four days. Many new facets or clues are manifested during this time. Sometimes clues may appear in a matter of hours. This is why I have practiced the policy of waiting twelve to twenty-four hours before performing surgery in atypical surgical illnesses. It is surprising the number of pneumonias that first present themselves as acute abdominal problems.

* * *

Autopsy Findings

The peritoneal cavity contained approximately 1800 cc. of frank blood. There was a large, dark, purplish red, firm but not hard mass, apparently arising from the brim of the pelvis on the left and extending from the midline upwards to the diaphragm filling the left lateral gutter. Just prior to the bifurcation of the abdominal aorta there was an aneurysmal dilatation measuring $7\frac{1}{2}$ cm. across with a perforation $3\frac{1}{2}$ cm. posteriorly and slightly to the left of the midline. This area of rupture communicated with the dark purplish red mass.

DISABILITY COMPENSATION FORMS

A recent examination of the causes of delayed payments of Temporary Disability Insurance benefits reveals that in a large number of cases such delays have resulted from the failure of some attending physicians to return promptly to this Department the form requesting medical information necessary for payment of benefits.

Benefits cannot be paid under the Temporary Disability Insurance law without proper medical certification of an individual's disability for work by the attending physician. Accordingly, when there is a delay in obtaining such certification from the physician, this delays the worker's claim for benefits and means added hardship and inconvenience to him. It also increases the cost of operating the program.

We realize that you are just as interested as we in avoiding such delays and hardships. We, therefore, urge you to pay particular and *prompt* attention to these forms and thus assure their return to us as quickly as possible.

RHODE ISLAND MEDICAL JOURNAL
THE CROSSROADS OF ADOLESCENCE*continued from page 87*

ents and their particular society are responsibilities of any given community.

It seems advisable to establish responsibility in the teenager according to his ability to meet it. For example, deciding too early on his courses of study may result in extreme anxiety, and his decision may be based upon a desire to please parents and educators and to fulfill their expectations of him, rather than on his own needs and aptitudes.

On the other hand, the teenager can be given a clothes allowance and allowed to spend it without question. Advice such as "it's for your own good" should be meagerly applied, as the teenager is extremely sensitive to false standards. It is better to be honest and tell the teenager that he has to wait to do something or, indeed, that you think it best that he not do it at all. It may not satisfy him then because he feels so eager and enthusiastic, but it does not leave a bad taste or shattered faith—when he sees you do the same thing: for example, smoking, drinking, etc.

The particular problems for which parents seek help during this period can be listed as follows:

1. Neurotic symptoms
2. Learning or school problems
3. Psychosomatic disturbances
4. Delinquency
5. Psychoses
6. Asceticism

Thus, in adolescence the vestiges of immaturity and the signs of adult behavior admix. There are attempts to be independent while at the same time extreme dependence is manifested. The teenager tends to externalize his inner problems and confusions so that the world is all wrong. Because feelings wax and wane between these extremes, overindulgence and deprivation are frequently not needed when tomorrow usually brings entirely different feelings.

The challenge of the adolescent is to satisfy basic needs of love and security outside of the family. He turns away and out, wondering if the equipment provided by his family will be sufficient to obtain his goals. Attempting to master the forces of aggression and sexuality that arise within himself and at the same time to master the forces of nature outside of himself, he is torn between futile competitive strivings and the desire to be identified with a group that will accept him.

No matter how we try to the end of our days, we are engaged in this endless struggle and remain children emotionally, fighting our nursery battles—in business, in war, in the boxing ring and beauty parlor, the arts, as well as in science and religion.

The determinants of the adolescent's turmoil can be related to his earlier experiences within the

continued on page 100

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(1) Payne, R. W.; Shetlar, M. R.; Farr, C. H.; Hellbaum, A. A., and Ishmael, W. K.: J. Lab. & Clin. Med. 45:331, 1955. (2) Bunim, J. J.; Williams, R. R., and Black, R. L.: J. Chron. Dis. 7:168, 1955. (3) Holbrook, W. P.: M. Clin. North America 39:405, 1955.

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THE CROSSROADS OF ADOLESCENCE

continued from page 98

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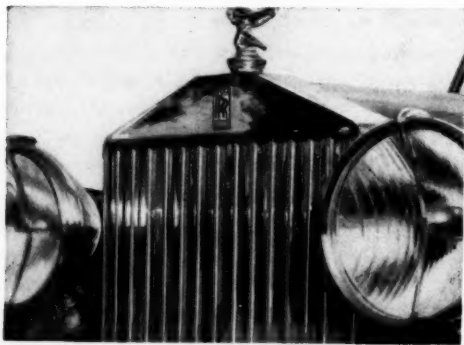
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structural and emotional setting of the family, and teenagers can handle their conflicts in several ways. The adolescent may retreat, afraid to attempt relationships with anyone and besieged by a deep sense of anger at both himself and his parents. On the other hand, he may seek everyone's approval lest they withdraw love and cause him to feel empty and depressed. If he is unable to express his erotic feelings to others, he may turn them inwards, imagining himself increasingly omnipotent and important. If this omnipotence is charged with aggressive urges and not supervised by adequate control, delinquent behavior is likely to result.

While the teenager recognizes his need to reach out beyond himself even to the infinite (to religion, aesthetics and political fields), it is characteristic for him to feel he is incomplete and singularly alone. This brings on the desire to get into contact with something—another being—or an idea outside of the self.

To consolidate the gains of childhood, this period of life must then establish sufficient ego strength so that the infantile impotence and dependence upon the family will not predominate. The chaotic self contradictions, the temporary regressions which usually accompany energetic change and growth, and the expanded social awareness are all necessary steps in the process leading to maturity and the development of a sense of personal identity and worth.

The teenager then faces the critical task of forging new and stronger characteristics out of the provocative and puzzling experiences of physical growth and conflicting demands of his culture into a strong personality that will enable him to find the completion that he needs in an acceptable way.

I would like to quote a poem by Ogden Nash* that portrays this struggle in a few words. It demonstrates rare insight.

O Adolescence, O Adolescence
I wince before thy incandescence
Thy Constitution young and hearty
Is too much for this aged party,
Thou standest with loafer flattened feet
Where bras and funny papers meet.
When anxious elders swarm about
Crying "where are you going?" thou criest "Out"
Leaving thy parents swamped in debt
For bubble gum and cigarettes.
Thou spurnest in no uncertain tone
The sirloin for the ice cream cone
Not milk but cola is thy potion.
Thou wearest earrings in the ocean
Blue jeans at dinner, if out of shorts,

*The author acknowledges with appreciation the permission of Mr. Ogden Nash to reprint his poem in this article.

And lipstick on the tennis courts.
 Forever thou whisperest, two by two
 Of who is madly in love with who.
 The car thou needest every day
 Let hub caps scatter where they may
 For it would start unfriendly talk
 If friends should chance to see thee walk
 Friends, heavens how they come and go
 Best pal today, tomorrow foe,
 Since to distinguish thou doest fail
 Twixt confidante and tattletale
 And blanchest to find the beach at noon
 With sacred midnight secrets strewn.
 Strewn! All is lost and nothing found
 Lord how thou leavest things around
 Sweaters and rackets in the stable
 And purse upon the drug store table
 And cameras rusting in the rain
 And daddies patience down the drain,
 Ah well, I must not carp and cavil
 I'll chew the spinach and spit out the gravel
 Remembering how my heart has leapt
 At times when me thou did accept.
 Still I'd like to be present, I must confess
 When thin own adolescents adolesce.

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THE NEW HOSPITAL AND ITS CHALLENGE

ANTHONY V. MIGLIACCIO, M.D., *Surgeon*, Rhode Island Hospital

One of the editors of the RHODE ISLAND MEDICAL JOURNAL was recently at a surgical meeting at the Rhode Island Hospital. Doctor Migliaccio, of the Surgical Staff, gave a short talk urging the members of the Surgical Staff to interest themselves in the production of papers. Of course this was a family gathering and he was talking only to Rhode Island Hospital workers but he expressed sentiments which we think should be taken to heart by the staffs of all our large hospitals hereabouts. The RHODE ISLAND MEDICAL JOURNAL is anxious to get case reports and papers from our different hospitals. Some of them have done remarkably well, but we have a feeling that we should be getting more good local work. We are pleased to present this talk.

.... THE EDITOR

THE PEOPLE of Rhode Island have built an edifice which stands out as a beacon that beckons the ill and the injured to its portals and then into our care. From that point on, the welfare of these unfortunate individuals becomes our responsibility.

There have been few instances in the history of this institution where this responsibility was not shouldered honorably by the unselfish individuals who made up the staff.

Another responsibility involves the training of interns and residents in the various specialties. More important than the material success of our graduates is the ethical standard which they have maintained. All of the boys with whom I have been in contact are respected men of their communities, both as citizens and as physicians, thus attesting to the fact that our trainees are impressed and improved not only by our scientific but also by our moral and ethical approach to the problems which confront us daily. This is most gratifying.

A third responsibility and one in which we have

failed, concerns contributions to the improvement of medical knowledge. A tremendous amount of clinical material has been at our disposal. *What have we done with it?*

Instead of gathering and profiting by the wealth of knowledge and information contained within our charts, we have allowed it to lie unmolested and to disappear finally into microfilm, from which it will never be resurrected.

Never will we be considered seriously as a teaching hospital unless we arouse ourselves into action; this action must be guided by a group into the channel which will yield the greatest return.

It is my feeling that the Rhode Island Hospital is a clinical institution and that its research and contribution should be along clinical lines. I believe that basic, scientific research should be left in the hands of the university hospitals where the necessary extensive laboratory services are available.

Let us train our younger staff members and our residents in the gathering and presentation of this valuable material. Then, let us discuss and profit from it. If the results are unsatisfactory, let us make changes. If the results are what they should be, then let us publish them, so that the sum knowledge of our experience may be added to that of others.

This then, I say to you, is our challenge: 1) let us continue with the excellent care of our patients, 2) let us continue the excellent training of our interns and residents in the scientific, spiritual and moral values, and 3) let us begin anew the gathering and scrutiny of our abundant clinical material.

Forgive me for taking up your valuable time with this, but as I approach sixty, I find that I am becoming mellow and philosophical. This institution and the ideals behind it have become a part of me and I can't help but take great pride in its accomplishment, nor can I keep myself from hoping that in the future our progress will show considerable accelerations.

HOSPITAL ASSOCIATION ELECTS

At its annual meeting the Hospital Association of Rhode Island elected the following officers for 1956:

President: William K. Turner, Director of the Newport Hospital

Vice President: I. Herbert Scheffer, M.D., Executive Director, Miriam Hospital

Treasurer: Nicholas E. Janson, Business Manager, State Hospital for Mental Diseases

The Association has also established a central office at 162 Angell Street, Providence, Rhode Island (Telephone—TEmpLe 1-0900) under the supervision of Mr. Wade C. Johnson as executive director.

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See page 111

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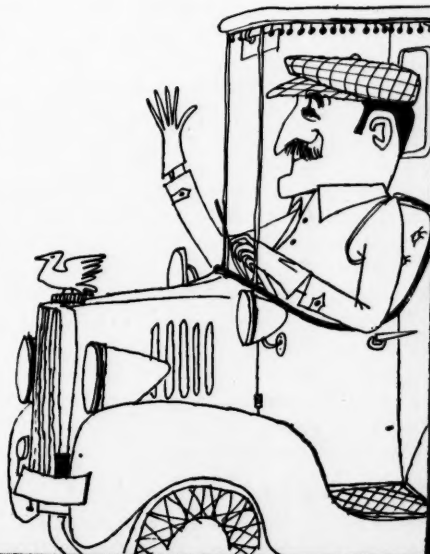
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DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

The 109th Annual Meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, January 9, 1956. The meeting was called to order by the president, Dr. Francis H. Chafee at 8:30 P.M.

Annual Report of the Secretary

Dr. Michael DiMaio, secretary, read his annual report for the year 1955. It was moved that the report be received and placed on file.

Annual Report of the Treasurer

Dr. Robert G. Murphy, treasurer, read his annual financial report for the year 1955. It was voted to receive the report and place it on file.

Report of the Executive Committee

The executive secretary reported that at its most recent meeting the Executive Committee had taken the following actions:

1. It reviewed the annual report of the treasurer, approved of it and also instructed the treasurer to invest \$1,000 of the surplus funds in a contingency fund for the Association.

2. It approved of a tentative budget for 1956 with an estimated total for expenditures of \$9,000, and it recommended the adoption of the budget.

3. It reviewed the report of the Advisory Committee to the Medical Bureau which reported an operating loss for the 1955 fiscal year, and it approved of revisions in the subscription charges for subscribers, effective February 1, 1956. It also approved of recommendations to expand the facilities of the Bureau.

4. The Executive Committee also moved that the annual dues for 1956 be established at \$20 for active members, and \$5 for associate members.

Action: It was moved that the report of the Executive Committee and the recommendations incorporated therein be approved and adopted. The motion was seconded and passed.

Presidential Address

Dr. Francis H. Chafee delivered his presidential address in which he discussed the objects of the Association and the ways in which the membership could and should fulfill its obligations to carry out these objectives.

Election of Officers for 1956

The president reported that there had been no counter-nominations to the slate of officers nominated by the Executive Committee and submitted to the membership in printed form in advance of the meeting.

Action: It was moved that the slate of officers and delegates to the Rhode Island Medical Society, as nominated by the Executive Committee, be elected to serve the Association until the next Annual Meeting. The motion was seconded and adopted.

Introduction of New President

Dr. Francis H. Chafee appointed Drs. Herman A. Lawson and Frank Dimmitt to escort the new president, Dr. Robert R. Baldridge, to the rostrum. Dr. Baldridge spoke briefly thanking the membership for electing him to be their leader in 1956, and expressing the hope that he would continue to have the support of all members in carrying on the work and activities of the Association. At the conclusion of his remarks, he presented Dr. Francis H. Chafee, as a token of appreciation from the Association, an engraved gavel. Dr. Chafee thanked the Association for its gift, the Committees for their service, and the members for their loyal support, and the executive office and its staff for their conscientious service throughout the year.

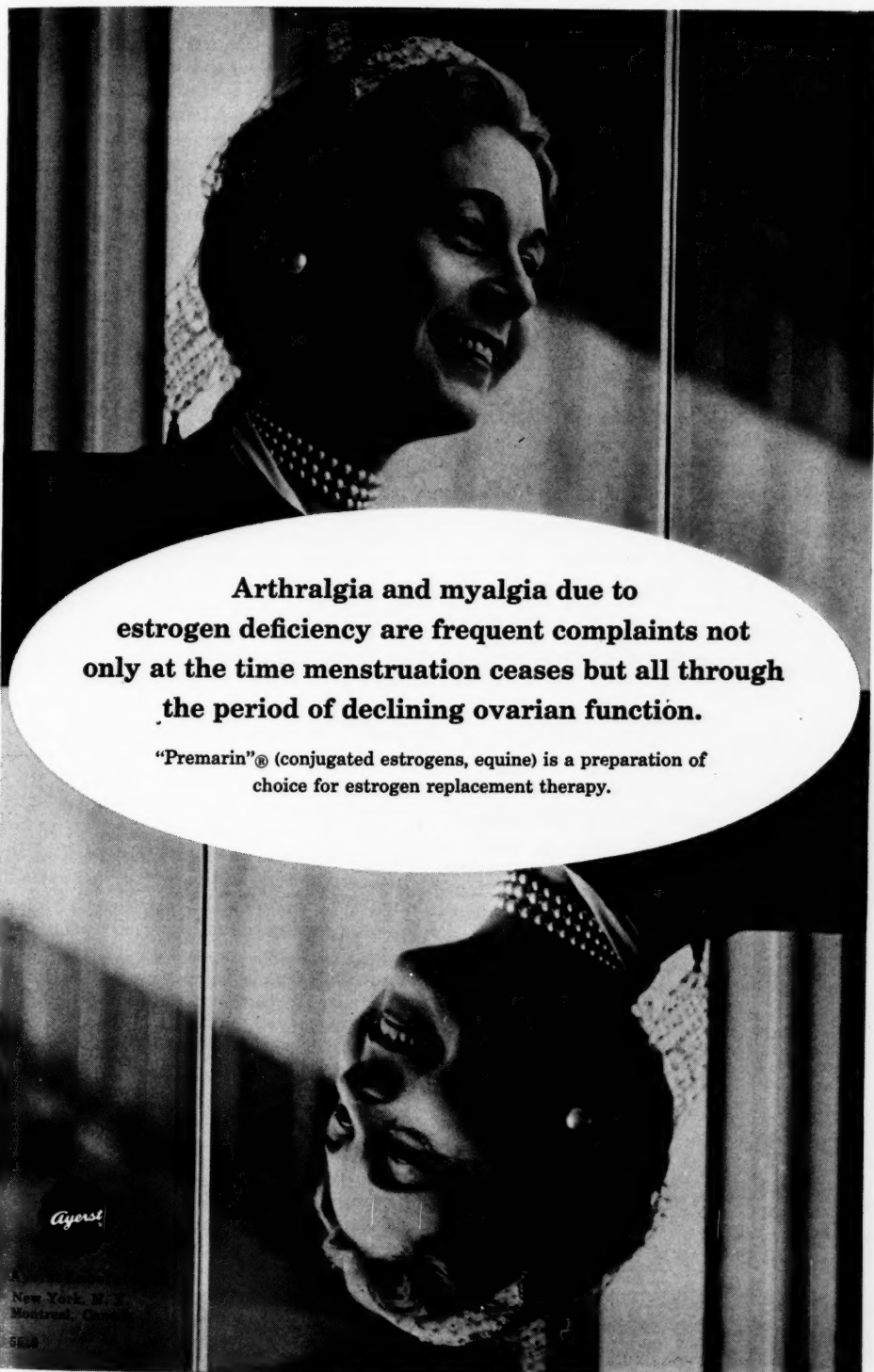
Dr. Chafee then introduced to the membership the other officers elected as follows:

Thomas L. Greason, M.D. . . .	<i>Vice President</i>	
Michael DiMaio, M.D. . . .	<i>Secretary</i>	
Robert G. Murphy, M.D. . . .	<i>Treasurer</i>	
John E. Donley, M.D. . . .	<i>Trustee, R. I. Medical Library</i>	
Irving A. Beck, M.D.		} <i>Executive Committee</i>
William S. Nerone, M.D.		
Louis I. Kramer, M.D.		
Joseph G. McWilliams, M.D.		

Appointment of Committees

Dr. Chafee reported that the incoming president would notify the members to be appointed to Committees and the complete roster would be published at a subsequent date in the RHODE ISLAND MEDICAL JOURNAL.

continued on page 106



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PROVIDENCE MEDICAL ASSOCIATION

*continued from page 104***Reports of Committees**

The president announced that any committee reports filed with the secretary would undoubtedly be published in the RHODE ISLAND MEDICAL JOURNAL. He invited any committee chairmen desiring to bring any recommendations before the Association for action to do so. No recommendations were presented.

Applications for Membership

The secretary reported that the Executive Committee recommended for election to active membership the following physicians: Enold H. Dahlquist, M.D., Rhode Island Hospital, Providence, Rhode Island; George A. Ernst, M.D., 463 Broadway, Providence, Rhode Island; and Johannes Virks, M.D., Box 5, Howard, Rhode Island.

Action: It was moved that these physicians be elected active members of the Association. The motion was seconded and adopted.

Award of Membership Certificates

The president awarded membership certificates to the following: James F. Boyd, Jr., M.D.; Patrick Finbarr O'Mahony, M.D.; Ralph Forward Pike, M.D.; and Banice M. Webber, M.D.

These physicians were elected to active membership at the meeting of the Association in November.

Scientific Program

Dr. Chafee presented as the guest speaker of the evening Dr. Charles S. Houston, consultant in medicine, Manchester VA Hospital; cardiologist, Exeter Hospital who spoke on *Personal Observations made at very high Altitudes*.

The first part of Dr. Houston's talk was devoted to the mechanism of acclimatization at high altitudes. It was obvious from his talk that his personal experience at high altitudes produced a considerable amount of valuable data on the physiology of respiration. He projected slides to show in a simplified manner the effect of a rarefied atmosphere on breathing.

The second part of his talk was devoted to his personal experiences of his several expeditions to the Himalayas. His talk was illustrated by beautiful Kodachrome slides. The talk was very well received.

The meeting was adjourned at 10:15 P.M.

Attendance was 106.

Collation was served.

MICHAEL DiMAIO, M.D., *Secretary*

* * *

Annual Report of the Secretary

Again it is my privilege and honor to submit, as secretary of the Association, an annual report of

RHODE ISLAND MEDICAL JOURNAL

our major activities during 1955.

The scientific lectures arranged for the seven monthly meetings by the Program Committee continued the excellent pattern of previous years and the attendance at the meetings was excellent.

The Association continued, both through its committees and by individual participation of physicians, to play an important role in the community programs for the improvement of the health and welfare of the people within our medical association district. Very active support was given the poliomyelitis vaccine program, the United Community Fund, the White House Conference on Education, and other important activities.

Of major interest to the profession was the revision of the Association By-Laws with clarification regarding the authority of what was previously the Committee on Ethics and Department, and is now the Grievance Committee. The Association's group health and accident plan was greatly expanded to provide two additional years of coverage for sickness, and, with supplemental insurance, extended sickness coverage for five years and accidental benefits for life.

The action resulting in the closing of Butler Hospital received careful study and review by the Executive Committee, and the Association joins with the entire community in expressing its regret that such an outstanding institution has had to cease its operations at its present site.

The annual dinner and golf tournament, always a very pleasant and memorable gathering for the membership, was held at the Pawtucket Golf Club and it drew the usual fine attendance.

The Medical Bureau completed its sixth year of operation with complete utilization of all its available facilities, with the resultant necessity that further expansion will be undertaken in the coming months to accommodate the membership of the Association requesting its services. Again the Bureau compiled an outstanding year of aid to persons seeking the services of a physician in an emergency, one of the finest examples of public service of any private organization in the city.

The Executive Committee meet regularly during the year to carry on the business of the Association, to review qualifications of applicants for membership, and in general represent the membership in its relations with all community agencies in the area. As the result of a recommendation from the Executive Committee the House of Delegates of the state medical society has issued new regulations relative to physician announcements in newspapers, and specialty listings in telephone and other directories.

The total membership of the Association at the end of the year was 654, of whom 62 were associate members.

continued on page 108

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PROVIDENCE MEDICAL ASSOCIATION

continued from page 106

During 1955 the Association elected sixteen to active membership, one to associate membership, and one member was reinstated to active membership. Ten members resigned from membership upon moving out of the district, and three were dropped for non-payment of dues.

During the year the Association lost the following members by death: George H. Alexander, M.D. (April 29, 1955); J. Joseph Hoey (February 4, 1955); Frank J. Jacobson, M.D. (February 20, 1955); John Langdon, M.D. (April 20, 1955); Joseph G. O'Connell, M.D. (March 3, 1955); Herbert G. Partridge, M.D. (November 23, 1955); Harvey Sanborn, M.D. (September 10, 1955); Constant E. Schradieck, M.D. (May 2, 1954); George L. Shattuck, M.D. (March 20, 1955).

To the officers, the Executive Committee and the various other committees, and the executive staff of the Association, I express my appreciation and thanks for the assistance given me during the year.

MICHAEL DiMAIO, M.D., *Secretary*

KENT COUNTY MEDICAL SOCIETY

At the Annual Meeting of the Kent County Medical Society held on December 21, 1955, the following officers were elected to serve for 1956:

President: Peter C. Koch, Jr., M.D.
 Vice President: Francis E. Temple, M.D.
 Treasurer: John A. Mack, M.D.
 Secretary: Paul G. Haltenberger, M.D.
 Delegates: Peter C. H. Erinakes, M.D.
 Edmund J. Hackman, M.D.
 Russell P. Hager, M.D.

WASHINGTON COUNTY MEDICAL SOCIETY

At the Annual Meeting of the Washington County Medical Society held on January 11, 1956, the following officers were elected to serve for the current year:

President: Martin J. O'Brien, M.D.
 (Wickford)
 1st Vice President: Frederick C. Eckel, M.D.
 (Westerly)
 2nd Vice President: James A. McGrath, M.D.
 (Wakefield)
 Secretary-Treasurer: Elmer T. Gale, M.D.
 (Narragansett)
 Auditor: Henry B. Potter, M.D.
 Censors: Attilio L. Manganaro, M.D., Freeman B. Agnelli, M.D., and William H. Tully, Jr., M.D.
 Delegates: Thomas A. Nestor, M.D., Hartford P. Gongaware, M.D., and James A. McGrath, M.D.

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Councillor: Samuel Nathans, M.D.

Alternate Councillor: Joseph L. C. Ruisi, M.D.

* * *

A meeting of the Washington County Medical Society was held on October 19, 1955 at the Haver-sham Inn, Westerly. The meeting was called to order by the president, Dr. C. S. Capalbo, at 11:30 A.M.

The minutes of the previous meeting were read and approved.

Communications were read.

There were no committee reports.

Dr. Nestor spoke concerning the numerous auto accidents and said that the Society should begin discussions to curb these needless losses of life and limb. The death toll is constantly mounting and Dr. Nestor felt that it was very important that every effort be made to prevent highway accidents. Various factors were discussed. Considerable thought from a local to a national level was suggested.

Dr. Jones brought up the question as to whether speed could be controlled by a governor installed on automobiles, with a federal fine for traveling without one. Dr. Tatum thought that the speedometer design could be changed. She considered it a bad psychological effect because of the tremendous range of speed indicated on the dial.

Dr. Nathans brought up the question as to whether auto manufacturers wanted to do anything about this in view of the increase in horsepower in modern autos.

Dr. Cerrito suggested that a committee be appointed to work with Dr. Nestor. Dr. Capalbo suggested a committee of one to discuss this problem at the next meeting.

Drs. Tatum and Jones and Dewees volunteered to work with Dr. Nestor.

Dr. Neida Ogden suggested that the National Safety Council be invited to provide a speaker for the next meeting.

The question of dues was mentioned by Dr. O'Brien, and Dr. Tatum suggested that bills be sent to those in arrears.

Dr. O'Brien brought up the need to protect the very valuable records of the Washington County Medical Society dating from the first meeting on January 31, 1848 to October 8, 1947. It was suggested that they be kept at the Rhode Island Medical Library for safety. Dr. Tatum suggested that the secretary be directed to deposit the records in the Rhode Island Medical Library and title it *Volume I*. This was seconded by Dr. Ruisi, and passed unanimously.

A very excellent film on cancer detection was shown under the auspices of Dr. George Waterman as part of the cancer detection program of the

concluded on next page

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Rhode Island Medical Society. This film was shown by Leo J. Conley, Jr., of the Society.

After the film there was a brief question period and the meeting adjourned at 1:30 P.M. Attendance at the meeting was 24.

* * *

The quarterly meeting of the Washington County Medical Society was held at the Dunes Club, Narragansett, on July 13, 1955.

The meeting was opened by the president, Dr. C. S. Capalbo at 11:35 A.M. The minutes of the previous meeting were read and approved.

The report on various communications was given. A letter of January 18, 1955 from the Rhode Island Medical Society pointed out that we were entitled to an increase in the number of delegates. Dr. Potter nominated Dr. J. P. Jones as a delegate. Dr. Ruisi seconded this motion, and it was passed unanimously.

A review of officers of the Society was made by Dr. Capalbo and the secretary. This showed that the term of office of Dr. Agnelli expires in 1958, Dr. Warren in 1956. An additional censor is needed, and Dr. Ruisi moved that Dr. Tully be appointed. This was seconded by Dr. Jones, and passed unanimously.

Dr. Tatum reported on the transaction of the maturing of the \$500 bond. She had purchased with the funds 25 shares of Northern States Power totaling \$421.88. The balance was credited to the checking account of the society. This stock pays dividends on the twentieth of the month four times a year.

The secretary read a communication from the Rhode Island Medical Society dated April 15, 1955, concerning the reporting of the minutes of the district Society meetings. Such reports should list only reports of action taken such as motions passed, members elected, future programs proposed, elections, etc. A detailed list for such reports was appended.

Dr. Charles Ashworth, guest speaker, felt that each society should report each meeting.

Another communication dated May 18, 1955 requested the attention of members be brought to the following actions of the House of Delegates:

1. The House voted to recommend to the A.M.A. that it bill its members in Rhode Island directly, effective in January 1956, and not through the offices of the Rhode Island Medical Society.

The house voted to refer to the Committee on Public Policy and Relations a recommendation from the Providence Medical Association asking for a review of the entire problem of physician advertising, with particular reference to office display signs, telephone and other directory listings, newspaper displays, etc.

The House approved the recommendation of the Cancer Committee of the Society which calls for discontinuance this year of the annual Cancer Conference for physicians and the suggestion that each district Medical Society be asked to cooperate with the Cancer Committee by assigning one meeting annually for a Cancer Education program.

Dr. Capalbo suggested that the October meeting be set aside as a Cancer Education program and directed the Secretary to communicate with Dr. George W. Waterman to arrange details.

A further communication dated May 18, 1955 was read.

"The Board of Directors of Physicians Service has voted that each district Medical Society in Rhode Island be asked to name a three-member committee representing surgery, medicine and any other specialty to serve as a liaison group with the Physicians Service administrative office and the Claims Committee."

To complete the suggested liaison group with Physicians Service, Dr. Ruisi nominated Dr. Cerito. Dr. Cerito nominated Dr. Tully. Dr. H. P. Gongaware is already a member of the Board of Directors of Physicians Service. Both of these nominations were seconded and passed unanimously.

Dr. Capalbo introduced as guest speaker Dr. Charles Ashworth. Dr. Ashworth gave an informal talk concerning some of the socio-economic factors in medicine today, his object being to stimulate thinking along these lines at the district society level. The chief thought behind the appointment of the three man liaison group with Physicians Service was to present problems arising directly to the Physicians Service rather than have disputes reach the Physicians Service in a round-about way. He pointed out that Physicians Service is quite pressed to get an increase in premium rate, and is also interested in increasing the rate of Physicians Service. The Blue Cross is \$95,000 in the red for the first five months. An additional X-ray benefit is being studied by the roentgenologists of the State. Dr. Ashworth pointed out that the utility and use exceeds the national level by 3% to 4%.

Numerous other details were pointed out, followed by a question period.

The meeting adjourned at 1:00 P.M. Attendance was 28.

MARTIN J. O'BRIEN, M.D., *Secretary*

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CANCER CONFERENCE FOR RHODE ISLAND PHYSICIANS

WEDNESDAY, MARCH 14, 1956

At the R. I. Medical Society Library..... 1:30 P.M.

Panel Discussion

"Management of the Patients with Advanced Cancer"

I. SURGICAL MANAGEMENT OF THE PATIENT WITH ADVANCED CANCER

David Lyall, M.D., of New York City. Professor of Clinical
Surgery, Postgraduate Medical School, New York University;
Director, Tumor Service, University Hospital.

II. HORMONAL MANAGEMENT OF ADVANCED MAM- MARY CARCINOMA

George C. Escher, M.D., of New York City. Associate, Sloan-
Kettering Institute; Instructor in Medicine, Cornell University
Medical School; Assistant Attending Physician, Medical Serv-
ice, Memorial Hospital and Ewing Hospital.

III. RECENT ADVANCES IN IRRADIATION OF CANCER

Milton Friedman, M.D., of New York City. Associate Pro-
fessor of Clinical Radiology, New York University; Director,
Supervoltage Irradiation, Hospital for Joint Diseases.

MILK COMMISSION REPORT — PROVIDENCE MEDICAL ASSOCIATION, 1955

CERTIFIED MILK in Providence during 1955 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Hampshire Hills Farm, Wilton, N. H.; Hillside Farm, Cranston, R. I.

Through the courtesy and cooperation of the Boston Commission we have accepted their certification of one farm from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart. During the past year approximately 315 samples have been tested and we have found three bacteria counts above the legal standard among this group.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

This Commission, three years ago, discontinued the sale of Raw Certified Milk in the Providence market to conform with the standards in most of the larger cities. The legal standard for Pasteurized Certified milk is still 500 colonies per ml. and the actual count on all samples examined by this Commission the past year was 33 colonies per ml. The prepasteurized count on this milk must be under 10,000 and actual count was 1488 colonies per ml.

Vitamin D Certified Milk is defined as whole Certified Milk rendered antirachitic by irradiation or by the addition of a concentrate and shall be of sufficient vitamin potency to show, by biological assay, a content of at least 400 U.S.P. units per quart.

The Wisconsin Alumni Research Foundation of Madison, Wisconsin, is doing the assaying of

Vitamin D from Hillside Farm and the results have been entirely satisfactory. Two tests per year are required by this Commission.

Certified Fat-free (Skim) Milk, containing not more than 0.05 per cent butter fat, and with Vitamin A added has conformed to the standards set by the American Association of Medical Milk Commissions.

It will be noted from the tables that this Commission has tested samples of raw certified milk to ascertain the pre-pasteurized counts and this averaged 1488 bacteria per ml. The legal standard is 10,000 per ml. Also it should be noted that the butter fat content of the skimmed milk consistently averaged 0.1 per cent.

The American Association of Medical Milk Commission in their Methods and Standards for the Production of Certified Milk, require that each producer shall make or have made, once per month, a titration of Brucella agglutinins in the whey of the milk, whether the milk is raw or pasteurized. All titrations on the whey of the milk obtained from raw milk from Hillside Farm during the past year have been negative.

The Commission is indebted to Professor Stuart of Brown University for his continued cooperation in supervising our laboratory work at Brown University.

FRANK I. MATTEO, M.D., *Chairman*

JOHN T. BARRETT, M.D.

D. WILLIAM BELL, M.D.

GEORGE E. BOWLES, M.D.

BERTRAM H. BUXTON, JR., M.D.

HAROLD G. CALDER, M.D.

JOHN P. GRADY, M.D.

HENRY E. UTTER, M.D.

REUBEN C. BATES, M.D., *Secretary*

MONTHLY AVERAGES OF CERTIFIED MILK FOR 1955

	CHERRY HILL H. P. HOOD			HAMPSHIRE HILLS			HILLSIDE FARM								
	Pasteurized			Pasteurized			Pasteurized			Skimmed with Vit. A & D			Raw		
	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.	B.F.	T.S.	Bacteria per C.C.
January.....	4.2	12.58	6	4.2	12.48	11	4.2	12.40	25	0.1	8.09	25			
February.....	4.2	12.47	8	4.1	12.57	12	4.2	12.50	13	0.1	8.31	8			
March.....	4.1	12.39	6	4.0	12.38	5	4.2	12.52	5	0.1	8.16	9	3.9	11.96	720
April.....	4.1	12.27	7	4.4	12.77	9	4.4	12.74	4	0.1	8.26	10	3.4	11.11	480
May.....	4.0	12.42	4	4.0	12.50	30	4.4	12.75	25	0.1	8.37	23			
June.....	4.1	12.31	4	4.3	12.79	115	4.3	12.56	6	0.1	8.18	100	4.0	11.95	6400
July.....	3.9	12.04	71	4.0	12.09	286	3.9	11.97	59	0.1	7.95	73	5.6	13.87	380
August.....	4.0	12.03	35	4.0	12.18	228	3.7	11.79	41	0.1	8.18	118			
September.....	3.9	12.20	39	4.0	12.41	22	4.1	12.72	14	0.1	8.38	183			
October.....	4.0	12.27	3	4.1	12.62	10	4.2	12.90	38	0.1	8.31	26			
November.....	4.0	12.62	6	4.2	13.00	7	4.1	12.81	14	0.1	8.45	17			450
December.....	4.0	12.46	3	4.1	12.87	4	4.2	12.99	5	0.1	8.25	9	4.1	12.60	500
Yearly Average.....	4.0	12.34	16	4.1	12.55	61	4.1	12.55	20	0.1	8.24	50	4.2	12.29	1488

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PHYSICIAN — HOSPITAL RELATIONSHIPS

Staff Association as Clinic Group for Industrial Employee Physical Examinations

STATEMENT BY THE COUNCIL OF THE RHODE ISLAND MEDICAL SOCIETY

THE COUNCIL of the Rhode Island Medical Society has recently reviewed the problem arising at a hospital in the Providence district where it was suggested by a trustee of the hospital that the professional staff be utilized at the hospital to conduct physical examinations of persons engaged in the industry over which the said trustee exercises supervision. The proposal, in the opinion of the Council, had as its basic reason a reduced fee service by reason of mass examinations by a group of physicians at a centrally located clinic, i.e., the hospital in this instance.

The Council is most anxious, as is its Committee on Industrial Health, to develop ways and means by which there will be greater participation by physicians in industrial medical practice, and greater participation by industry in promoting annual physical examinations of employed personnel. However, the Council does not believe that the proposal for the utilization of hospital staffs and facilities for any industrial examination is proper.

The legal implications are sufficient to warrant the opinion that the action would place the hospital in the practice of medicine. The law establishes a hospital in this state as "an institution for the lodging, care and treatment of persons suffering from disease or other abnormal physical or mental conditions." The law also sets forth clearly that the practice of medicine in Rhode Island is restricted to physicians certified by the State Department of Health following the fulfillment of stated requirements.

It should be noted further that in most hospitals the medical services of the interns and residents are under the professional supervision of an attending medical staff and are only a small part of the total medical services rendered therein, most of the medical services being rendered by individual licensed practitioners who have placed their own patients in the hospital. This is a far different situation from where a corporation operates a hospital by a salaried staff and then, through the medium of this staff, engages in the practice of healing by treating persons who are patients of the corporation and not patients of any individual physician.

Therefore it would seem to the Council that the

original proposal must first be viewed in its proper perspective, namely, as a professional relationship involving the utilization of professional services of doctors of medicine by a hospital in competition with private practice.

Second, the Council calls attention to the Principles of Medical Ethics to which the Fellows of the Society subscribe: (Chapter VII, Section 5)—"A physician should not dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned. Such a procedure is beneath the dignity of professional practice and is harmful alike to the profession of medicine and the welfare of the people."

In the opinion of the Council the professional staff of the hospital in question acted wisely in rejecting the proposal as originally submitted and in undertaking to set up a program for the examinations by a group of physicians at their respective private offices.

The Council recognizes that many industrial leaders are endorsing and even directly supporting out of corporate earnings programs of medical service for non-occupational conditions. The Council is most desirous of furthering such programs in the interest of the general health of the worker. It seeks through its Committee on Industrial Health to develop occupational medical programs that will permit the examining physician to go into the industrial plant to observe working conditions, if necessary, and thereby to be able to appraise in detail the physical and emotional capacity of the worker for his assigned position.

The Council not only urges industry to take a greater interest in occupational medicine, but it also urges the Fellows of the Rhode Island Medical Society to take an equal interest in modern concepts and training to render the highest possible type of occupational medicine in Rhode Island. Such a concept embraces a knowledge of all phases of the worker's life—occupational as well as non-occupational.

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Tuesday and Wednesday, May 1 and 2

GENERAL MEETING

Thursday, May 3

ANNUAL DINNER

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Thursday, May 3

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BOOK REVIEWS

PERIPHERAL VASCULAR DISEASES by Edgar V. Allen, M.D., Nelson W. Barker, M.D., and Edgar A. Hines, Jr., M.D. With Associates in the Mayo Clinic and Mayo Foundation. W. B. Saunders Co., Phil., 1955. 2nd ed. \$13.00

A standard work of *PERIPHERAL VASCULAR DISEASE* finally has emerged with its second edition. This has been a long awaited step especially during this era of tremendous and radical strides in the field of vascular surgery.

This volume itself is presented in readable fashion with organizational improvement. The plates continue to be of considerable value. It appears that the revision is truly an adequate one. A completely rewritten chapter on special methods of investigation warrants praise for it reflects the progress made in this realm. It seems fitting that as more space is given to the advances in peripheral vascular disease diagnosis and therapy, deletions should be in such chapters as gross and microscopic anatomy of vessels.

The entire textbook seems geared to modern thought with adequate discussion given to the role of medical therapy in peripheral vascular disease. It is gratifying to note the deserved increase in space allotted to the problems of this field as benefited by surgical treatment. It is in the discussion of such therapy directed toward vascular diseases, injuries and deformities with the accompanying diagrams and photographs that this volume excels.

This alone makes the addition of this second edition a necessity to any physician's library whatever his field of endeavor.

V. M. PAHIGIAN, M.D.

HANDBOOK OF PEDIATRICS by Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. Lange Medical Publications, Los Altos, California, 1955. \$3.00

This small book (seven by four inches) contains a tremendous amount of up-to-date information on practically all the diseases and emotional problems of children.

Despite its compactness, it is extremely readable and has many excellent sections. Those on laboratory tests and pediatric procedures are certainly worthy of mention, but the index of household

poisons and their antidotes, where each poison is listed by its commercial or common name, is worth the modest purchase price alone.

This book would be a valuable addition to any library, or as a permanent fixture in the accident room where pediatric emergencies abound.

GERALD SOLOMONS, M.D.

OBSTETRICS by J. P. Greenhill, M.D. 11th ed. W. B. Saunders Company, Phil., 1955. \$14.00

In this eleventh edition of his text on obstetrics, Dr. Greenhill has produced an extremely complete and up-to-date volume. Most of the out-dated text and illustrations which were repeated in the DeLee editions have been replaced by new sections written by men who are authorities on their various subjects.

The sections on analgesia and anaesthesia, and erythroblastosis and the Rh factor, are especially good. The illustrations in the chapter on physiology and conduct of labor are excellent.

The chapter on the psychology of labor and puerperium reflects the modern emphasis on this subject. Written by a psychiatrist, it presents ideas which are not completely accepted by obstetricians.

This edition retains for Dr. Greenhill's text, its position as one of the two classic textbooks of obstetrics.

WILLIAM J. MACDONALD, M.D.

A TEXTBOOK OF MEDICINE edited by Russell S. Cecil, and Robert F. Loeb. W. B. Saunders, Philadelphia, 1955. \$15.00

The rapid advance of medicine in general, and the broadening of scope of the specialty of internal medicine in particular, is well epitomized in the present, the ninth, edition of this standard textbook. Although only four years have elapsed since the previous edition, the current volume includes thirty-nine articles on new subjects. In addition, fifty-eight fresh treatises on subjects previously covered have become necessary. This is indeed a contrast to the slow pace of our medical forbears, when a textbook such as Galen, might remain "Standard" (and static) for fifteen or more centuries! The articles on diseases not previously included, includes such "new" diseases as epidemic

concluded on page 118

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BOOK REVIEWS

concluded from page 116

hemorrhagic fever, cat scratch disease, and burning feet syndrome. Also accounting for the expansion, is the inclusion of conditions formerly regarded as belonging solely to other specialties, such as the painful shoulder, which is now known to be of at least as much concern to the internist and cardiologist as to the orthopedist, and petrositis which can no longer be regarded as solely a matter for the otologic surgeon. As mentioned in previous reviews of this text, there is no better index of the progress and medical thought and practice than the sequential editions of a standard text.

It is impossible adequately to survey such an encyclopedic compendium, but the distinguished list of contributors, comprising as it does many of the outstanding figures in modern American medicine, assures authoritative discussion.

As in the previous recent editions, the format continues attractive and legible.

IRVING A. BECK, M.D.

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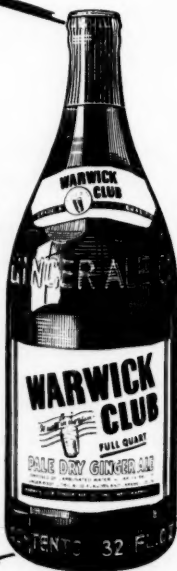


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